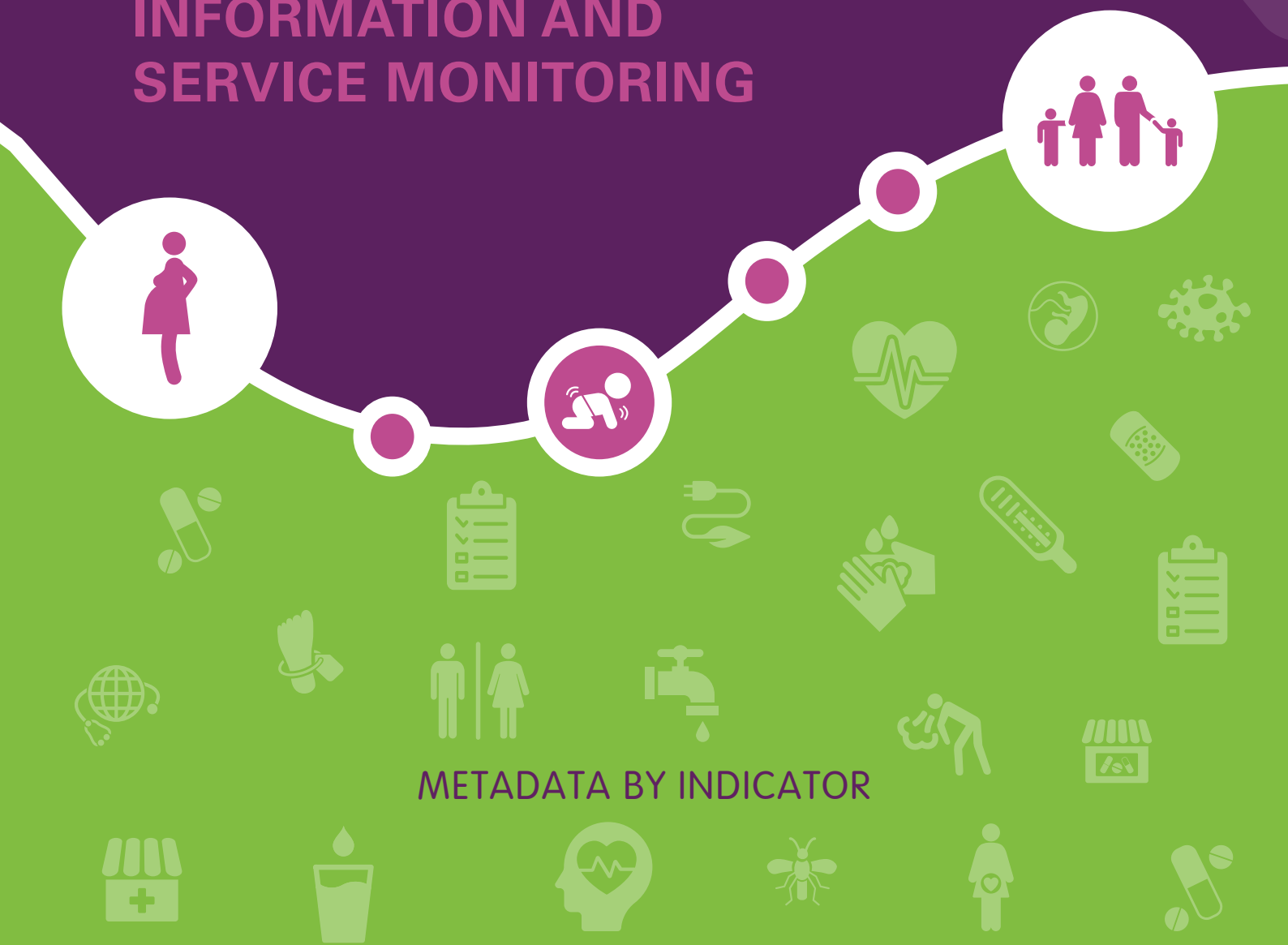
Analysis and use
of community-based
health service data

GUIDANCE FOR COMMUNITY HEALTH WORKERS STRATEGIC INFORMATION AND SERVICE MONITORING



METADATA BY INDICATOR

unicef for every child
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UN WOMEN
UNAIDS
Stop TB Partnership
The ROCKEFELLER FOUNDATION
Gavi The Vaccine Alliance
HEALTH DATA COLLABORATIVE

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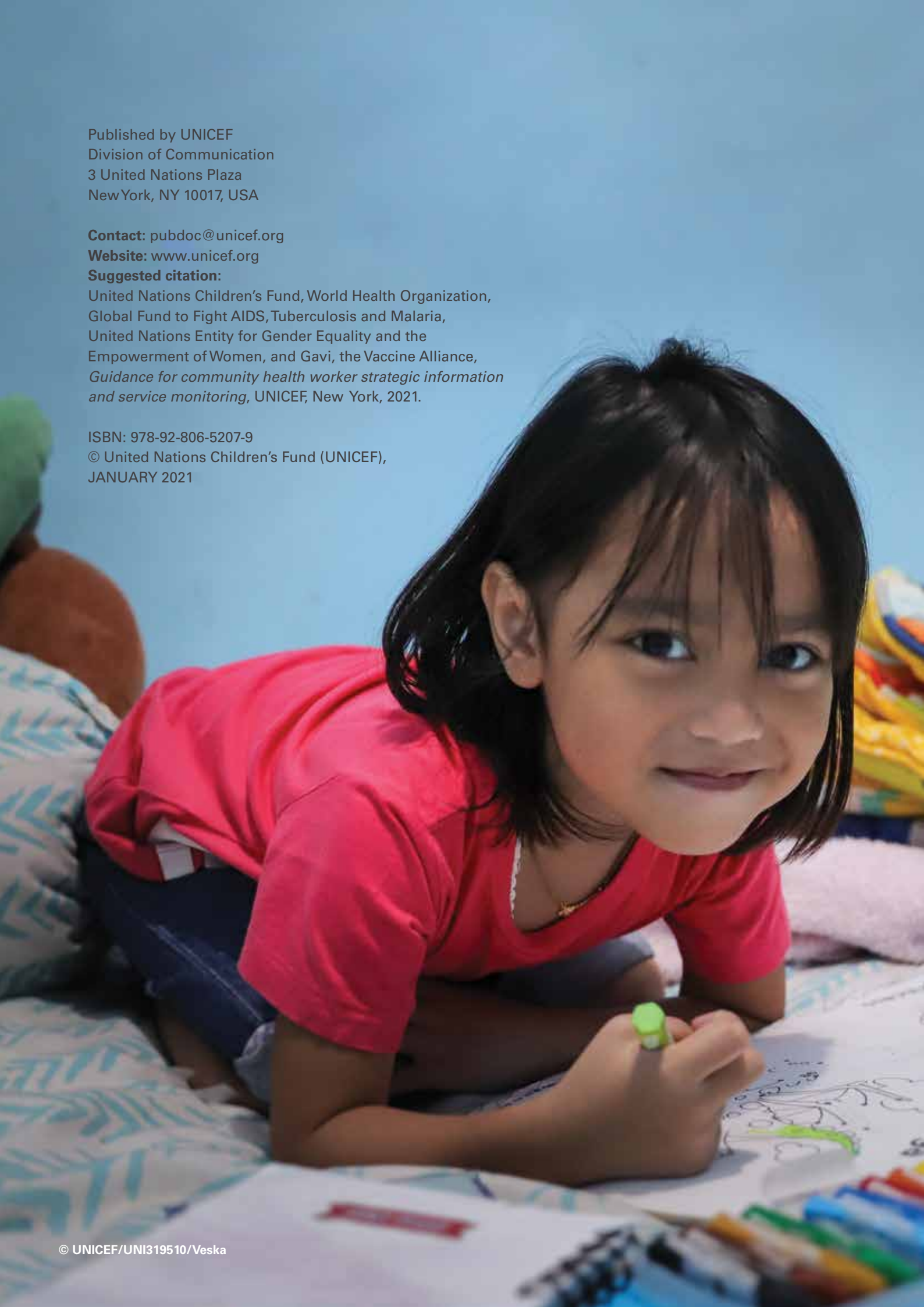

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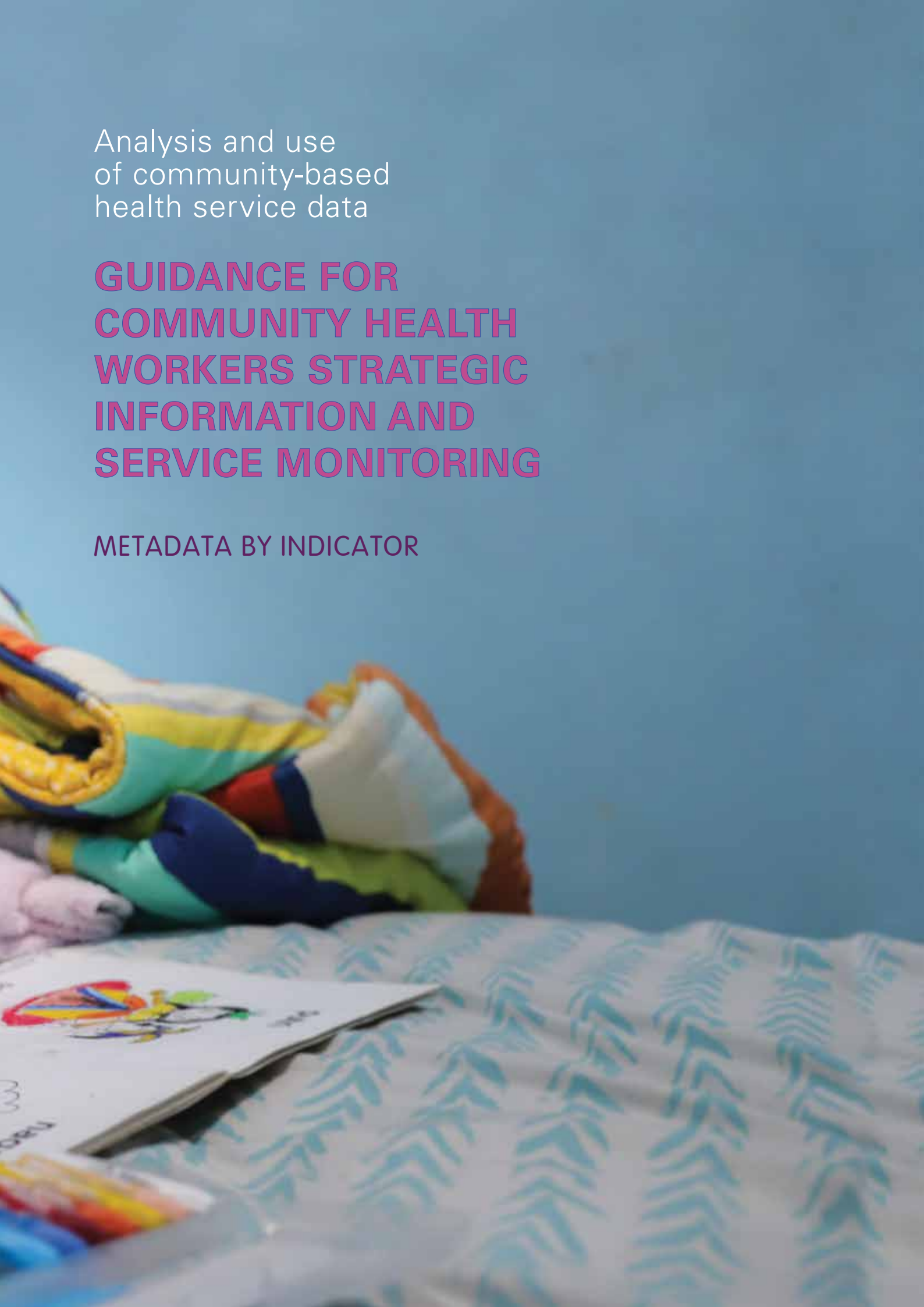

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METADATA BY INDICATOR

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1. NUMBER OF HOUSEHOLDS IN THE CATCHMENT AREA

COMMENT

A household is a small group of persons who share the same living accommodation, who pool some, or all, of their income and wealth, and who consume certain types of goods and services collectively, mainly housing and food.

CHW TASK

Map households in the catchment area.

CHW DATA POINTS TO COLLECT

Number of households in the catchment area.

NUMERATOR

Number of households in the catchment area.

DENOMINATOR

None.

DISAGGREGATION

Basic

- Geographic area
- Households with children under 5

Advanced

- Socioeconomic status (wealth quintile)
- Ethnic group
- Migratory status

MATURITY LEVEL

B.

FREQUENCY

At least once a year.

DIGITALIZATION

Disaggregation can be automatic, especially for ethnic group, geographic area, education level and socioeconomic status, if feasible.

ALIGNMENT

Disaggregation can be automatic, especially for ethnic groups, geographic areas, and socioeconomic status, if feasible.

REFERENCES

None.

2. NUMBER OF LIVE BIRTHS

COMMENT

It is important to measure how many live births occur in the community, to better inform policies and programmes. The number of live births is used as a denominator to calculate values for other indicators (e.g. neonatal mortality, etc.) and is fundamental (1). Even if live births are reported monthly in certain countries, it is useful to review at least once a year during household visits how many live births occurred in the community.

Disaggregation allows differentiation of which live births occurred in the community versus at the facility, and also the number of adolescent births.

The frequency of reporting will depend on the frequency of CHW household visits. Regularity of the household assessments is important to limit issues of field enumeration. Clear guidance on common issues should be specified – for instance, how to count birth if there is a difference between the place of occurrence and the place of usual residence, as these differences tend to be larger for smaller administrative areas.

CHW TASK

Recording of births in the community.

CHW DATA POINTS TO COLLECT

Number of new live births in the reporting period.

NUMERATOR

Number of new live births in the reporting period: The complete expulsion or extraction from its mother of a product of conception, irrespective of the duration of the pregnancy, which, after such separation, breathes or shows any other evidence of life.

DENOMINATOR

None.

DISAGGREGATION

Basic

- Place of delivery: at the facility, in the community
- Place of occurrence and place of usual residence
- Geographic area
- Age of mother (10-14, 15-19, 20+)
- Sex (male, female, intersex)
- Birthweight and gestational age

Advanced

- Socioeconomic status (wealth quintile)
- Main education level
- HIV status of mother and child
- Ethnic group
- Migratory status
- Mother going to school
- Marital status

MATURITY LEVEL

A.

FREQUENCY

At least once a year.

DIGITALIZATION

Disaggregation can be automatic, especially for age, geographic area, education level and socioeconomic status, if feasible.

ALIGNMENT

SDG: 3.7.2: Adolescent birth rate (aged 10–14 years; aged 15–19 years) per 1000 women in that age group *(2)*

WHO 100 indicators: Adolescent birth rate; Total fertility rate *(3)*

Global Strategy for Women, Children and Adolescents' Health: Adolescent birth rate *(4)*

Health Data Collaborative (HDC) facility guidance: Reproductive, maternal, newborn, child and adolescent health and nutrition (RMNCAH): Institutional delivery *(5)*

WHO Global nutrition monitoring framework: Adolescent fertility rate *(6)*

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6. Global nutrition monitoring framework: operational guidance for tracking progress in meeting targets for 2025. Geneva: WHO; 2017 (https://www.who.int/publications/i/item/9789241513609, accessed 31 August 2020).

3. NUMBER OF INFANTS IN THE CATCHMENT AREA (0 TO LESS THAN 1 YEAR OLD)

COMMENT

Infants are children 0 to less than 1 year old.

CHW TASK

Map the number of infants in the catchment area.

CHW DATA POINTS TO COLLECT

Number of infants in the catchment area.

NUMERATOR

Number of infants in the catchment area.

DENOMINATOR

None.

DISAGGREGATION

Basic

- Geographic area
- Sex (male, female)

Advanced

- Socioeconomic status (wealth quintile)
- Main education level
- Ethnic group
- Migratory status

MATURITY LEVEL

B.

Longitudinal tracking is necessary to avoid double counting.

FREQUENCY

At least once a year.

DIGITALIZATION

Disaggregation can be automatic, especially for ethnic group, geographic area, education level and socioeconomic status, if feasible.

ALIGNMENT

None.

REFERENCES

None.

4. NUMBER OF CHILDREN IN THE CATCHMENT AREA (1 TO LESS THAN 5 YEARS OLD)

CHW TASK

Map the number of children in the catchment area (1 to less than 5 years old).

CHW DATA POINTS TO COLLECT

Number of children in the catchment area (1 to less than 5 years old).

NUMERATOR

Number of children in the catchment area (1 to less than 5 years old).

DENOMINATOR

None.

DISAGGREGATION

Basic

- Geographic area
- Age (years)
- Sex (male, female)

Advanced

- Socioeconomic status (wealth quintile)
- Main education level
- Ethnic group
- Migratory status

MATURITY LEVEL:

B.

Longitudinal tracking is necessary to avoid double counting.

FREQUENCY

At least once a year.

DIGITALIZATION

Disaggregation can be automatic, especially for ethnic group, geographic area, education level and socioeconomic status, if feasible.

ALIGNMENT

None.

REFERENCES

None.

5. NUMBER OF CHILDREN IN THE CATCHMENT AREA (5 TO LESS THAN 10 YEARS OLD)

CHW TASK

Map the number of children in the catchment area (5 to less than 10 years old).

CHW DATA POINTS TO COLLECT

Number of children in the catchment area (5 to less than 10 years old).

NUMERATOR

Number of children in the catchment area (5 to less than 10 years old).

DENOMINATOR

None.

DISAGGREGATION

Basic

- Geographic area
- Age (years)
- Sex (male, female)

Advanced

- Socioeconomic status (wealth quintile)
- Main education level
- Ethnic group
- Migratory status

MATURITY LEVEL

B.

Longitudinal tracking is necessary to avoid double counting.

FREQUENCY

At least once a year.

DIGITALIZATION

Disaggregation can be automatic, especially for ethnic group, geographic area, education level and socioeconomic status, if feasible.

ALIGNMENT

None.

REFERENCES

None.

6. NUMBER OF YOUNG ADOLESCENTS IN THE CATCHMENT AREA (10–14 YEARS OLD)

CHW TASK

Map the number of young adolescents in the catchment area (10–14 years old).

CHW DATA POINTS TO COLLECT

Number of young adolescents in the catchment area (10–14 years old).

NUMERATOR

Number of young adolescents in the catchment area (10–14 years old).

DENOMINATOR

None.

DISAGGREGATION

Basic

- Geographic area
- Age (years)
- Sex (male, female, other)

Advanced

- Socioeconomic status (wealth quintile)
- Main education level
- Ethnic group
- Migratory status

MATURITY LEVEL

B.

Longitudinal tracking is necessary to avoid double counting.

FREQUENCY

At least once a year.

DIGITALIZATION

Disaggregation can be automatic, especially for ethnic group, geographic area, education level and socioeconomic status, if feasible.

ALIGNMENT

None.

REFERENCES

None.

7. NUMBER OF OLDER ADOLESCENTS IN THE CATCHMENT AREA (15–19 YEARS OLD)

CHW TASK

Map the number of older adolescents in the catchment area (15–19 years old).

CHW DATA POINTS TO COLLECT

Number of older adolescents in the catchment area (15–19 years old).

NUMERATOR

Number of older adolescents in the catchment area (15–19 years old).

DENOMINATOR

None.

DISAGGREGATION

Basic

- Geographic area
- Age (years)
- Sex (male, female, other)

Advanced

- Socioeconomic status (wealth quintile)
- Main education level
- Ethnic group
- Migratory status

MATURITY LEVEL

B.

Longitudinal tracking is necessary to avoid double counting.

FREQUENCY

At least once a year.

DIGITALIZATION

Disaggregation can be automatic, especially for ethnic group, geographic area, education level and socioeconomic status, if feasible.

ALIGNMENT

None.

REFERENCES

None.

8. NUMBER OF HOUSEHOLDS IN THE CATCHMENT AREA

COMMENT

The number of pregnant women should be part of the household assessment of the headcount in the catchment area.

CHW TASK

Map the number of pregnant women in the catchment area.

CHW DATA POINTS TO COLLECT

Number of pregnant women in the catchment area.

NUMERATOR

Number of pregnant women in the catchment area.

DENOMINATOR

None.

DISAGGREGATION

Basic

- Geographic area
- Age (years)

Advanced

- Socioeconomic status (wealth quintile)
- Main education level
- Ethnic group
- Migratory status

MATURITY LEVEL

B.

Longitudinal tracking is necessary to avoid double counting.

FREQUENCY

At least once a year.

DIGITALIZATION

Disaggregation can be automatic, especially for ethnic group, geographic area, education level and socioeconomic status, if feasible.

ALIGNMENT

None.

REFERENCES

None.

9. NUMBER OF ADULTS IN THE CATCHMENT AREA

CHW TASK

Map the number of adults in the catchment area.

CHW DATA POINTS TO COLLECT

Number of adults in the catchment area

NUMERATOR

Number of adults in the catchment area.

DENOMINATOR

None.

DISAGGREGATION

Basic

- Geographic area
- Age (20–24, 25–29, 30–34, 35–39, 40–44, 45–49, 50–54, 55–59, 60–64, 65–69, 70–74, 75–79, 80+)

Advanced

- Socioeconomic status (wealth quintile)
- Main education level
- Ethnic group
- Migratory status

MATURITY LEVEL

B.

Longitudinal tracking is necessary to avoid double counting.

FREQUENCY

At least once a year.

DIGITALIZATION

Disaggregation can be automatic, especially for ethnic group, geographic area, education level and socioeconomic status, if feasible.

ALIGNMENT

None.

REFERENCES

None.

10. MAIN DRINKING-WATER SOURCE

COMMENT

Seasonal variations are essential to consider when analysing data trends – people may use different sources during dry or rainy seasons. As access to households may also be more difficult during rainy seasons, data may not reflect the specific use during that time.

Unimproved sources are: unprotected well, unprotected spring, surface water.

CHW TASK

Identification of main drinking-water source.

CHW DATA POINTS TO COLLECT

- Identification of main drinking-water source ("What is the main source of drinking-water for members of your household?").
- Number of households visited.

NUMERATOR

Number of households with access to an improved source of water (piped water, protected dug wells, protected springs, rainwater and packaged or delivered water).

DENOMINATOR

Number of households in the catchment area.

DISAGGREGATION

Basic

- Type of improved source: Piped water, boreholes or tubewells, protected dug wells, protected springs, rainwater and packaged or delivered water
- Geographic area
- Season (dry, rainy season)

Advanced

- Socioeconomic status
- Higher education level

MATURITY LEVEL

B.

Longitudinal follow-up is important to avoid double counting households and to track improvement.

FREQUENCY

At least once a year (consider seasonality).

DIGITALIZATION

Disaggregation can be automatic for the geographic area, education level and socioeconomic status if the information is already collected with a household identifier.

A preset menu can also facilitate the collection of types of water sources.

ALIGNMENT

SDG: 6.1.1: Proportion of population using safely managed drinking-water services *(1)*

WHO 100 indicators: Population using safely managed drinking water services *(2)*

Global Strategy for Women's, Children's and Adolescents' Health: Population using safely managed drinking water services *(3)*

WHO/UNICEF Joint Monitoring Programme for Water Supply, Sanitation and Hygiene (JMP): Core questions on drinking water, sanitation and hygiene for household surveys 2018 update: Drinking-water *(4)*

REFERENCES

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2. 2018 global reference list of 100 core health indicators (plus health-related SDGs). Geneva: WHO; 2018 (https://apps.who.int/iris/bitstream/handle/10665/259951/WHO-HIS-IER-GPM-2018.1-eng.pdf, accessed 31 August 2020).
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4. WHO/UNICEF Joint Monitoring Programme for Water Supply, Sanitation and Hygiene. Core questions on drinking water, sanitation and hygiene for household surveys: 2018 update. New York: UNICEF and WHO; 2018 https://washdata.org/sites/default/files/documents/reports/2019-03/JMP-2018-core-questions-for-household-surveys.pdf, accessed 31 August 2020).

11. TIME TO COLLECT DRINKING-WATER

COMMENT

This indicator should be considered in combination with the indicator on use of improved water sources to estimate the population using "basic drinking-water services" (i.e. use of an improved water source provided collection time is not more than 30 minutes for a round trip, including queuing).

Seasonal variations are essential to consider when analysing data trends – people may use different sources during dry or rainy seasons. As access to households may also be more difficult during rainy seasons, data may not reflect the specific use during that time.

CHW TASK

Identification of time to access drinking-water.

CHW DATA POINTS TO COLLECT

Time to get water (if collection, it includes time to go, collect and come back).

NUMERATOR

Number of households needing not more than 30 minutes to access drinking-water.

The number of minutes should include travel, time queuing, and fetching.

DENOMINATOR

Number of households in the catchment area.

DISAGGREGATION

Basic

- Geographic area
- In own dwelling, in own yard
- Season (dry, rainy season)

Advanced

- Socioeconomic status
- Higher education level

MATURITY LEVEL

B.

Longitudinal follow-up is important to avoid double counting households and to track improvement.

FREQUENCY

At least once a year (consider seasonality).

DIGITALIZATION

Disaggregation can be automatic for the geographic area, education level and socioeconomic status if the information is already collected with a household identifier.

Data can also be cross-checked with the indicator on drinking-water availability.

A preset menu can also facilitate the collection of types of water sources.

ALIGNMENT

SDG: 6.1.1: Proportion of population using safely managed drinking-water services *(1)*

WHO 100 indicators: Population using safely managed drinking water services *(2)*

Global Strategy for Women's, Children's and Adolescents' Health: Population using safely managed drinking water services *(3)*

WHO/UNICEF Joint Monitoring Programme for Water Supply, Sanitation and Hygiene (JMP): Core questions on drinking water, sanitation and hygiene for household surveys 2018 update: Drinking-water *(4)*

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1. Sustainable Development Goals. SDG indicators metadata repository. In: United Nations Statistics Division [website] (https://unstats.un.org/sdgs/metadata/, accessed 31 August 2020).
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12. LOCATION OF DRINKING-WATER POINT

CHW TASK

Identification of source where water is collected from.

CHW DATA POINTS TO COLLECT

Identification of source where drinking-water is collected from.

NUMERATOR

Number of households that have water on premises.

DENOMINATOR

Number of households in the catchment area.

DISAGGREGATION

Basic

- **Location:** In own dwelling, in own yard/plot, elsewhere

Advanced

- None

MATURITY LEVEL

B.

Longitudinal follow-up is important to avoid double counting households and to track improvement.

FREQUENCY

At least once a year (consider seasonality).

DIGITALIZATION

Disaggregation can be automatic for the geographic area, education level and socioeconomic status if the information is already collected with a household identifier.

ALIGNMENT

SDG: 6.1.1: Proportion of population using safely managed drinking-water services *(1)*

WHO 100 indicators: Population using safely managed drinking water services *(2)*

Global Strategy for Women's, Children's and Adolescents' Health: Population using at least basic drinking-water services (%) *(3)*

WHO/UNICEF Joint Monitoring Programme for Water Supply, Sanitation and Hygiene (JMP): Core questions on drinking water, sanitation and hygiene for household surveys 2018 update: Drinking-water *(4)*

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13. DRINKING-WATER QUALITY AT THE SOURCE

COMMENT

New bacteriological rapid tests are available to be done by CHWs. Also, pool tests are available for free residual chlorine measurement in treated water.

When reporting this indicator, it is critical to report which type of tests were conducted.

Results of the rapid quality test conducted on site by the health workers (new rapid E. Coli tests are available, which can be done in the field).

CHW TASK

Rapid water quality test (E. Coli) conducted and results reported (eventually including free residual chlorine tests).

CHW DATA POINTS TO COLLECT

Results of the rapid water quality test (E. Coli) conducted (eventually including free residual chlorine tests).

NUMERATOR

Number of negative E. Coli tests.

DENOMINATOR

Number of tests conducted in the catchment area.

DISAGGREGATION

Basic

- Rapid E. Coli test: Positive/Negative
- Type of test used and volume tested
- Water supply type: Unimproved sources (unprotected wells, unprotected springs, surface water); improved sources (piped water, protected dug wells, protected springs, rainwater and packaged or delivered water)

Advanced

- Possibility of also measuring free residual chlorine by using a pool test; and measuring other key chemical pollutants (i.e. arsenic and fluoride)

MATURITY LEVEL

B.

Longitudinal follow-up is important to avoid double counting households and to track improvement.

FREQUENCY

At least once a year (consider seasonality).

DIGITALIZATION

saggregation can be automatic for the geographic area/source, or by the household identifier.

A preset menu can also facilitate the collection of results from the rapid test.

ALIGNMENT

SDG: 6.1.1: Proportion of population using safely managed drinking-water services *(1)*

WHO 100 indicators: Population using safely managed drinking water services *(2)*

Global Strategy for Women's, Children's and Adolescents' Health: Population using at least basic drinking-water services (%) *(3)*

WHO/UNICEF Joint Monitoring Programme for Water Supply, Sanitation and Hygiene (JMP): Core questions on drinking water, sanitation and hygiene for household surveys 2018 update: Sanitation *(4)*

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14. AVAILABILITY OF DRINKING-WATER WHEN NEEDED

CHW TASK

Identification of availability of drinking-water when needed.

CHW DATA POINTS TO COLLECT

- Identification of households that did not have sufficient quantities of drinking-water when needed ("In the last month, has there been any time when your household did not have sufficient quantities of drinking water when needed?").
- Number of households visited.

NUMERATOR

Number of households that did not have sufficient quantities of drinking-water when needed.

DENOMINATOR

Number of households in the catchment area.

DISAGGREGATION

Basic

- Geographic area
- Season

Advanced

- Socioeconomic status
- Higher education level

MATURITY LEVEL

B.

Longitudinal follow-up is important to avoid double counting households and to track improvement.

FREQUENCY

At least once a year (consider seasonality).

DIGITALIZATION

Disaggregation can be automatic for the geographic area, education level and socioeconomic status if the information is already collected with a household identifier.

ALIGNMENT

SDG: 6.1.1: Proportion of population using safely managed drinking-water services *(1)*

WHO 100 indicators: Population using safely managed drinking water services *(2)*

Global Strategy for Women's, Children's and Adolescents' Health: Population using at least basic drinking-water services (%) *(3)*

WHO/UNICEF Joint Monitoring Programme for Water Supply, Sanitation and Hygiene (JMP): Core questions on drinking water, sanitation and hygiene for household surveys 2018 update: Drinking water *(4)*

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1. Sustainable Development Goals. SDG indicators metadata repository. In: United Nations Statistics Division [website] (https://unstats.un.org/sdgs/metadata/, accessed 31 August 2020).
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15. ACCESS TO HANDWASHING FACILITIES WITH WATER AND SOAP AVAILABLE ON PREMISES (HOUSEHOLD LEVEL)

COMMENT

Ash, soil and mud are not counted as sufficient handwashing materials for global indicators.

CHW TASK

Identification of handwashing facilities with water and soap available on premises.

CHW DATA POINTS TO COLLECT

- Identification of water and soap availability for handwashing on premises ("Can you please show me where members of your household most often wash their hands?").
- Number of households visited.

NUMERATOR

Number of households with access to handwashing facilities with water and soap available on premises.

DENOMINATOR

Number of households in the catchment area.

DISAGGREGATION

Basic

- Geographic area
- Type of facilities:
  - Fixed facility observed (sink/tap): In dwelling, in yard/plot
  - Mobile object observed (bucket/kettle)
- Availability of soap observed: yes/no

Advanced

- Socioeconomic status
- Higher education level

MATURITY LEVEL

B.

Longitudinal follow-up is important to avoid double counting households and to track improvement.

FREQUENCY

At least once a year.

DIGITALIZATION

Disaggregation can be automatic for the geographic area, education level and socioeconomic status if the information is already collected with a household identifier.

A preset menu can also facilitate the collection of water and soap availability.

ALIGNMENT

SDG: 6.2.1: Proportion of population using safely managed sanitation services, including a handwashing facility with soap and water *(1)*

WHO 100 indicators: Population with handwashing facility with soap and water) *(2)*

Global Strategy for Women's, Children's and Adolescents' Health: Population with basic handwashing facilities at home (%) *(3)*

WHO/UNICEF Joint Monitoring Programme for Water Supply, Sanitation and Hygiene (JMP): Core questions on drinking water, sanitation and hygiene for household surveys 2018 update: Hygiene *(4)*

REFERENCES

1. Sustainable Development Goals. SDG indicators metadata repository. In: United Nations Statistics Division [website] (https://unstats.un.org/sdgs/metadata/, accessed 31 August 2020).
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16. USE OF IMPROVED SANITATION FACILITIES

COMMENT

Non-improved sanitation facilities are: on-site sanitation (pit latrines without slabs; hanging latrines; bucket latrines); open defecation.

CHW TASK

Identification of toilet facility available and used.

CHW DATA POINTS TO COLLECT

- Identification of toilet facility used ("What kind of toilet facility do members of your household usually use?").
- Number of households visited.

NUMERATOR

Number of households with access to improved sanitation facilities.

DENOMINATOR

Number of households in the catchment area.

DISAGGREGATION

Basic

- Geographic area
- Type of improved sanitation facilities:
  - **1 Networked sanitation:**
    - Flush-and-pour flush toilets connected to sewers
  - **2 On-site sanitation:**
    - Flush-and-pour flush toilets or latrines connected to septic tanks or pits
    - Ventilated improved pit latrines
    - Pit latrines with slabs
    - Composting toilets, including twin pit latrines and container-based systems

Advanced

- Socioeconomic status
- Higher education level

MATURITY LEVEL

Longitudinal follow-up is important to avoid double counting households and to track improvement.

FREQUENCY

At least once a year.

DIGITALIZATION

Disaggregation can be automatic for the geographic area, education level and socioeconomic status if the information is already collected with a household identifier.

A preset menu can also facilitate the collection of types of toilet facilities.

ALIGNMENT

SDG: 6.2.1: Proportion of population using safely managed sanitation services, including a handwashing facility with soap and water *(1)*

WHO 100 indicators: Population using safely managed sanitation services *(2)*

Global Strategy for Women's, Children's and Adolescents' Health: Population using at least basic sanitation services (%) *(3)*

WHO/UNICEF Joint Monitoring Programme for Water Supply, Sanitation and Hygiene (JMP): Core questions on drinking water, sanitation and hygiene for household surveys 2018 update: Sanitation *(4)*

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17. SHARING OF SANITATION FACILITIES

CHW TASK

Identification of shared sanitation.

CHW DATA POINTS TO COLLECT

- Identification of households sharing the sanitation facilities they use.
- Number of households visited.

NUMERATOR

Number of households sharing the sanitation facilities they use.

DENOMINATOR

Number of households in the catchment area.

DISAGGREGATION

Basic

- Shared with known households (not public), with general public
- Geographic area
- Type of improved sanitation facilities:
  - Networked sanitation: Flush-and-pour flush toilets connected to sewers
  - Flush-and-pour flush toilets or latrines connected to septic tanks or pits
  - Ventilated improved pit latrines
  - Pit latrines with slabs
  - Composting toilets, including twin pit latrines and container-based systems
- Type of unimproved sanitation facilities:
  - Flush/pour flush to open drain
  - Pit latrine without slab/open pit
  - Bucket
  - Hanging toilet/hanging latrine
  - No facility/bush/field

Advanced

- Socioeconomic status
- Higher education level

MATURITY LEVEL

B.

Longitudinal follow-up is important to avoid double counting households and to track improvement.

FREQUENCY

At least once a year.

DIGITALIZATION

Disaggregation can be automatic for the geographic area, education level and socioeconomic status if the information is already collected with a household identifier.

A preset menu can also facilitate the type of sharing.

ALIGNMENT

SDG: 6.2.1: Proportion of population using safely managed sanitation services, including a handwashing facility with soap and water *(1)*

WHO 100 indicators: Population using safely managed sanitation services *(2)*

Global Strategy for Women's, Children's and Adolescents' Health: Population using at least basic sanitation services (%) *(3)*

WHO/UNICEF Joint Monitoring Programme for Water Supply, Sanitation and Hygiene (JMP): Core questions on drinking water, sanitation and hygiene for household surveys 2018 update: Sanitation *(4)*

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18. EMPTYING OF ON-SITE SANITATION FACILITIES (SEPTIC TANKS AND PIT LATRINES)

CHW TASK

Identification of emptying of on-site sanitation facilities.

CHW DATA POINTS TO COLLECT

- Number of households using on-site sanitation facilities that have ever been emptied.
- Number of households using on-site sanitation facilities with on-site storage (latrines, septic tanks, composting toilets and twin pits).

NUMERATOR

Number of households using on-site sanitation facilities that have ever been emptied.

DENOMINATOR

Number of households using on-site sanitation facilities with on-site storage (latrines, septic tanks, composting toilets and twin pits).

DISAGGREGATION

Basic

- Type of on-site sanitation facilities with on-site storage: latrines, septic tanks, composting toilets and twin pits
- Emptying mode: removed by a service provider, buried in a covered pit, uncovered pit, open ground, water body, elsewhere
- Geographic area

Advanced

- Socioeconomic status
- Higher education level

MATURITY LEVEL

B.

Longitudinal follow-up is important to avoid double counting households and to track improvement.

FREQUENCY

At least once a year.

DIGITALIZATION

Disaggregation can be automatic for the geographic area, education level and socioeconomic status if the information is already collected with a personal identifier.

A preset menu can also facilitate the collection of types of on-site sanitation facilities and emptying modes.

ALIGNMENT

SDG: 6.2.1: Proportion of population using safely managed sanitation services, including a handwashing facility with soap and water *(1)*

WHO 100 indicators: Population using safely managed sanitation services *(2)*

Global Strategy for Women's, Children's and Adolescents' Health: Population using at least basic sanitation services (%) *(3)*

WHO/UNICEF Joint Monitoring Programme for Water Supply, Sanitation and Hygiene (JMP): Core questions on drinking water, sanitation and hygiene for household surveys 2018 update: Sanitation *(4)*

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19. PRIVATE PLACE TO WASH AND CHANGE DURING MENSTRUATION

CHW TASK

Identification of women and girls who have a private place to wash and change during menstruation.

CHW DATA POINTS TO COLLECT

- Number of women and girls who have a private place to wash and change during menstruation ("During your last menstrual period were you able to wash and change in privacy while at home?").
- Number of women and girls surveyed during household visits.

NUMERATOR

Number of women and girls who have a private place to wash and change during menstruation.

DENOMINATOR

Number of women and girls surveyed during household visits.

DISAGGREGATION

Basic

- Geographic area

Advanced

- Socioeconomic status
- Higher education level

MATURITY LEVEL

B.

Longitudinal follow-up is important to avoid double counting households and to track improvement.

FREQUENCY

At least once a year.

DIGITALIZATION

Disaggregation can be automatic for the geographic area, education level and socioeconomic status if the information is already collected with a household identifier.

ALIGNMENT

WHO/UNICEF Joint Monitoring Programme for Water Supply, Sanitation and Hygiene (JMP): Core questions on drinking water, sanitation and hygiene for household surveys 2018 update: Menstrual hygiene (1)

REFERENCES

1. WHO/UNICEF Joint Monitoring Programme for Water Supply, Sanitation and Hygiene. Core questions on drinking water, sanitation and hygiene for household surveys: 2018 update. New York: UNICEF and WHO; 2018 https://washdata.org/sites/default/files/documents/reports/2019-03/JMP-2018-core-questions-for-household-surveys.pdf, accessed 31 August 2020).

20. USE OF HYGIENE MATERIALS DURING MENSTRUATION

COMMENT

Experts advise against classifying menstrual hygiene materials as "hygienic/unhygienic" or "appropriate/inappropriate" and recommend focusing instead on whether they are "disposable" or "reusable".

CHW TASK

Identification of hygiene materials used by women and girls during menstruation.

CHW DATA POINTS TO COLLECT

- Number of women and girls using hygiene materials during menstruation ("During your last menstrual period what hygiene materials did you use?").
- Number of women and girls surveyed during household visits.

NUMERATOR

Number of women and girls using hygiene materials during menstruation.

DENOMINATOR

Number of women and girls surveyed during household visits.

DISAGGREGATION

Basic

- Type of materials: sanitary pads (disposable), sanitary pads (reusable), cloths (disposable), cloths (reusable), tampons (disposable), menstrual cups (reusable), other (disposable), other (reusable), nothing
- Geographic area

Advanced

- Socioeconomic status
- Higher education level

MATURITY LEVEL

B.

Longitudinal follow-up is important to avoid double counting households and to track improvement.

FREQUENCY

At least once a year.

DIGITALIZATION

Disaggregation can be automatic for the geographic area, education level and socioeconomic status if the information is already collected with a personal identifier.

ALIGNMENT

WHO/UNICEF Joint Monitoring Programme for Water Supply, Sanitation and Hygiene (JMP): Core questions on drinking water, sanitation and hygiene for household surveys 2018 update: Menstrual hygiene *(1)*

REFERENCES

1. WHO/UNICEF Joint Monitoring Programme for Water Supply, Sanitation and Hygiene. Core questions on drinking water, sanitation and hygiene for household surveys: 2018 update. New York: UNICEF and WHO; 2018 https://washdata.org/sites/default/files/documents/reports/2019-03/JMP-2018-core-questions-for-household-surveys.pdf, accessed 31 August 2020).

21. PROPORTION OF HOUSEHOLDS WITH PRIMARY RELIANCE ON CLEAN FUELS AND TECHNOLOGIES FOR COOKING

COMMENT

Almost 3 billion people, mostly in low- and middle-income countries, still rely on solid fuels (wood, animal dung, charcoal, crop wastes and coal) and kerosene burned in inefficient and highly polluting stoves for cooking. In 2016, household air pollution from cooking with polluting stoves and fuels was responsible for 3.8 million deaths, constituting 7.7% of global mortality, according to estimates by the World Health Organization (WHO) (1).

In the WHO Guidelines for indoor air pollution (2), household fuel combustion is used to define which cooking stoves are clean for health at the point of use. The question to the household could be phrased as: "What does your household use for cooking most of the time, including cooking food, making tea/coffee, boiling drinking water? Please tell me the cookstove or device that is used most of the time."

Clean cooking is determined by the performance of a particular fuel and technology combination, as measured by its emissions; fuels and technologies currently considered clean for health are: electricity, biogas, solar, alcohol-fuelled stoves, natural gas and liquefied petroleum gas (LPG).

Conversely, polluting fuels and technologies for cooking include: movable fire pan, three-stone stove/open fire, solid fuel stove with coal, charcoal, wood, straw, pellets, agricultural waste, animal waste/dung, garbage/plastic, liquid fuel stove that is used with fuel other than alcohol/ethanol.

CHW TASK

Identification of households with primary reliance on clean fuels and technologies for cooking.

CHW DATA POINTS TO COLLECT

- Identification of households with primary reliance on clean fuels and technologies for cooking.
- Number of households for which data were collected.

NUMERATOR

Number of households with primary reliance on clean fuels and technologies for cooking.

DENOMINATOR

Number of households in the catchment area.

DISAGGREGATION

Basic

- Geographic area
- Types of clean fuels and technologies for cooking: Solar cooker (thermal energy, not solar panels), electric stove, piped natural gas stove, biogas stove, LPG/cooking gas stove, liquid fuel stove with alcohol/ethanol (not kerosene)

Advanced

- Socioeconomic status
- Higher education level
- Gender of main stove user

MATURITY LEVEL

B.

Longitudinal follow-up is important to avoid double counting households and to track improvement.

FREQUENCY

At least once a year.

DIGITALIZATION

Disaggregation can be automatic for the geographic area, education level and socioeconomic status if the information is already collected with a personal identifier.

ALIGNMENT

SDG: 7.1.2: Proportion of population with primary reliance on clean fuels and technology *(3)*

WHO 100 indicators: Percentage of the population with primary reliance on clean fuels and technologies at the household level *(4)*

Global Strategy for Women's, Children's and Adolescents' Health: Population with primary reliance on clean fuels and technologies *(5)*

REFERENCES

1. Global Health Observatory (GHO) data [online database]. Mortality from household air pollution. In: World Health Organization [website] (https://www.who.int/gho/phe/indoor_air_pollution/burden/en/, accessed 31 August 2020).
2. WHO guidelines for indoor air quality: household fuel combustion. Geneva: WHO; 2014 (https://www.who.int/airpollution/publications/household-fuel-combustion/en/, accessed 31 August 2020).
3. Sustainable Development Goals. SDG indicators metadata repository. In: United Nations Statistics Division [website] (https://unstats.un.org/sdgs/metadata/, accessed 31 August 2020).
4. 2018 global reference list of 100 core health indicators (plus health-related SDGs). Geneva: WHO; 2018 (https://apps.who.int/iris/bitstream/handle/10665/259951/WHO-HIS-IER-GPM-2018.1-eng.pdf, accessed 31 August 2020).
5. Global Health Observatory (GHO) Data [online database]. Global Strategy for Women's, Children's and Adolescents' Health (2016–2030): Data portal. In: World Health Organization [website] (https://www.who.int/gho/publications/gswcah_portal/en/, accessed 31 August 2020).

22. PROPORTION OF HOUSEHOLDS WITH PRIMARY RELIANCE ON CLEAN FUELS AND TECHNOLOGIES FOR LIGHTING

COMMENT

Lighting is a basic need. However, around 780 million people lacked access to electricity in 2018 and thus resorted to kerosene lamps and, to a lesser extent, other polluting sources such as biomass and candles. In many low- and middle-income countries, those who have access to the grid often must rely on alternatives such as polluting kerosene lamps due to problems with electricity reliability and affordability. The presence of a connection to the grid does not ensure that a household uses "clean" energy for lighting. The household air pollution produced by the use of kerosene lamps, candles or biomass lighting sources is hazardous to health.

The question to the household could be phrased as: "What does your household use most of the time as energy for lighting, or as a light source? Please tell me the light source used for the most time each day."

Following the *WHO Guidelines for indoor air pollution: household fuel combustion (1)*, WHO considers clean fuels and technologies for lighting to include: electricity (including solar panels); solar-powered lantern or flashlight; rechargeable flashlight, mobile, torch or lantern; battery-powered flashlight, torch or lantern; biogas lamp; and LPG lamp.

Polluting lighting fuels and devices include biomass (firewood, grass and dung), candles, kerosene and oil lamps.

CHW TASK

Identification of households with primary reliance on clean fuels and technologies for lighting.

CHW DATA POINTS TO COLLECT

- Identification of households with primary reliance on clean fuels and technologies for lighting.
- Number of households for which data were collected.

NUMERATOR

Number of households with primary reliance on clean fuels and technologies for lighting.

DENOMINATOR

Number of households in the catchment area.

DISAGGREGATION

Basic

- Geographic area
- Types of clean fuels and technologies for lighting: Electricity (including solar panels); solar-powered lantern or flashlight; rechargeable flashlight, mobile, torch or lantern; battery-powered flashlight, torch or lantern; biogas lamp; LPG lamp

Advanced

- Socioeconomic status
- Higher education level

MATURITY LEVEL

B.

Longitudinal follow-up is important to avoid double counting households and to track improvement.

FREQUENCY

At least once a year.

DIGITALIZATION

Disaggregation can be automatic for the geographic area, education level and socioeconomic status if the information is already collected with a personal identifier.

ALIGNMENT

SDG: 7.1.2: Proportion of population with primary reliance on clean fuels and technology *(2)*

WHO 100 indicators: Percentage of the population with primary reliance on clean fuels and technologies at the household level *(3)*

Global Strategy for Women's, Children's and Adolescents' Health: Population with primary reliance on clean fuels and technologies *(4)*

REFERENCES

1. WHO guidelines for indoor air quality: household fuel combustion. Geneva: WHO; 2014 (https://www.who.int/airpollution/publications/household-fuel-combustion/en/, accessed 31 August 2020).
2. Sustainable Development Goals. SDG indicators metadata repository. In: United Nations Statistics Division [website] (https://unstats.un.org/sdgs/metadata/, accessed 31 August 2020).
3. 2018 global reference list of 100 core health indicators (plus health-related SDGs). Geneva: WHO; 2018 (https://apps.who.int/iris/bitstream/handle/10665/259951/WHO-HIS-IER-GPM-2018.1-eng.pdf, accessed 31 August 2020).
4. Global Health Observatory (GHO) Data [online database]. Global Strategy for Women's, Children's and Adolescents' Health (2016–2030): Data portal. In: World Health Organization [website] (https://www.who.int/gho/publications/gswcah_portal/en/, accessed 31 August 2020).

23. PROPORTION OF HOUSEHOLDS WITH PRIMARY RELIANCE ON CLEAN FUELS AND TECHNOLOGIES FOR HEATING

COMMENT

Heating is an essential energy service for people of all ages, but it is especially important for the health of infants, children, elderly and those who are ill. Even though it is such a fundamental need for so many, space heating is a largely overlooked source of household air pollution and health risk.

Use of inefficient and polluting space heaters produces dangerous levels of household air pollution in and around the home. Space heating with biomass and coal is estimated to lead to around 110 000 premature deaths each year.

The question to the household could be phrased as: "What does your household use to heat the home when needed? For example, do you use a space heater(s), or use your cookstove in the winter for warmth? Please tell me the heater, cookstove or heat system used most of the time."

Following the *WHO Guidelines for indoor air pollution (1)*, clean fuels and technologies for heating include: central heating; space heater (using electricity, piped natural gas, LPG/cooking gas, biogas, alcohol/ethanol, solar energy); cookstove (using electricity, piped natural gas, LPG/cooking gas, biogas, alcohol/ethanol, solar energy); heat pump.

Polluting fuels and technologies include: space heater (using gasoline/diesel [not in generator], kerosene/paraffin, coal, charcoal, wood, straw, pellets, agricultural waste, animal waste/dung, garbage/plastic); cookstove (using gasoline/diesel [not in generator], kerosene/paraffin, coal, charcoal, wood, straw, pellets, agricultural waste, animal waste/dung, garbage/plastic); moveable heating pan; open fire/three-stone stove.

CHW TASK

Identification of households with primary reliance on clean fuels and technologies for heating.

CHW DATA POINTS TO COLLECT

- Identification of households with primary reliance on clean fuels and technologies for heating.
- Number of households for which data were collected.

NUMERATOR

Number of households with primary reliance on clean fuels and technologies for heating.

DENOMINATOR

Number of households in the catchment area.

DISAGGREGATION

Basic

- Geographic area
- Types of clean fuels and technologies for heating: Central heating; space heater (using electricity, piped natural gas, LPG/cooking gas, biogas, alcohol/ethanol, solar energy); cookstove (using electricity, piped natural gas, LPG/cooking gas, biogas, alcohol/ethanol, solar energy); heat pump

Advanced

- Socioeconomic status
- Higher education level

MATURITY LEVEL

B.

Longitudinal follow-up is important to avoid double counting households and to track improvement.

FREQUENCY

At least once a year.

DIGITALIZATION

Disaggregation can be automatic for the geographic area, education level and socioeconomic status if the information is already collected with a personal identifier.

ALIGNMENT

SDG: 7.1.2: Proportion of population with primary reliance on clean fuels and technology *(2)*

WHO 100 indicators: Percentage of the population with primary reliance on clean fuels and technologies at the household level *(3)*

Global Strategy for Women's, Children's and Adolescents' Health: Population with primary reliance on clean fuels and technologies *(4)*

REFERENCES

1. WHO guidelines for indoor air quality: household fuel combustion. Geneva: WHO; 2014 (https://www.who.int/airpollution/publications/household-fuel-combustion/en/, accessed 31 August 2020).
2. Sustainable Development Goals. SDG indicators metadata repository. In: United Nations Statistics Division [website] (https://unstats.un.org/sdgs/metadata/, accessed 31 August 2020).
3. 2018 global reference list of 100 core health indicators (plus health-related SDGs). Geneva: WHO; 2018 (https://apps.who.int/iris/bitstream/handle/10665/259951/WHO-HIS-IER-GPM-2018.1-eng.pdf, accessed 31 August 2020).
4. Global Health Observatory (GHO) Data [online database]. Global Strategy for Women's, Children's and Adolescents' Health (2016–2030): Data portal. In: World Health Organization [website] (https://www.who.int/gho/publications/gswcah_portal/en/, accessed 31 August 2020).

Other

Residential heating with wood and coal: health impacts and policy options in Europe and North America. Copenhagen: WHO Regional Office for Europe; 2015 (https://www.euro.who.int/__data/assets/pdf_file/0009/271836/ResidentialHeatingWoodCoalHealthImpacts.pdf, accessed 31 August 2020).

24. NUMBER OF CONDOMS DISTRIBUTED

COMMENT

Condoms have been shown to be one of the most effective methods in preventing the sexual transmission of HIV and other sexually transmitted infections (STIs).

STIs include hepatitis and unintended pregnancy, with effectiveness that increases with consistent and correct use. Recommendations from WHO and the Joint United Nations Programme on HIV/AIDS (UNAIDS) emphasize that condom distribution and promotion is an efficacious intervention and a critical component of combination HIV prevention.

Proactive distribution of condoms is a strategy for ensuring adequate availability. By analysing the proportion of condoms distributed through different modalities, national programmes can optimize their investment in socially marketed and public-sector (that is, free) condom distribution.

An important factor to consider is the availability of condoms, so stock-outs of condoms should be measured in parallel.

The person-centred HIV patient monitoring and case surveillance guidelines discourage recording of key population status in patient monitoring tools (for example, registers and log books) used in general population facilities. Mechanisms can be adopted to ensure that key population status is linked to patient records only for data analysis. In the absence of this level of data security, disaggregating the priority indicators by key populations will be limited to facilities that offer services specifically for key populations.

CHW TASK

Condoms distribution.

CHW DATA POINTS TO COLLECT

Number of condoms distributed and sold during the reporting period.

NUMERATOR

Number of condoms distributed and sold during the reporting period.

DENOMINATOR

None.

DISAGGREGATION

Basic

- Condom type (male, female)
- Geographic area
- Gender
- Key populations (men who have sex with men, people living in prisons and other closed settings, people who inject drugs, sex workers, transgender people)

Advanced

None

MATURITY LEVEL

A.

FREQUENCY

12 months

DIGITALIZATION

None.

ALIGNMENT

Consolidated HIV strategic information guidelines: driving impact through programme monitoring and management *(1)*

REFERENCES

1. Consolidated HIV strategic information guidelines: driving impact through programme monitoring and management. Geneva: World Health Organization; 2020 (https://apps.who.int/iris/bitstream/handle/10665/331697/9789240000735-eng.pdf, accessed 31 August 2020).

25. NUMBER OF WOMEN AND ADOLESCENT GIRLS WHO INITIATE MODERN METHODS FOR FAMILY PLANNING IN THE COMMUNITY

COMMENT

WHO suggests that the initiation and maintenance by CHWs of injectable contraceptives using a standard syringe can be considered in the context of targeted monitoring and evaluation where a well-functioning programme already exists.

CHW TASK

Counseling for informed choice and distribution of modern methods of family planning with referral if needed.

CHW DATA POINTS TO COLLECT

Number of women and adolescent girls initiating a modern contraceptive method in the community during the reporting period.

NUMERATOR

Number of women and adolescent girls initiating a modern contraceptive method in the community during the reporting period.

DENOMINATOR

None.

DISAGGREGATION

Basic

- Age (10-14, 15-19, 20-24, 25-49, 50+)
- Postpartum (within 6 weeks after birth)
- Geographic area
- Types of modern methods distributed/administered **that can be initiated by CHWs in the country** (injectables; oral contraceptive pills; male and female condoms; vaginal barrier methods, including the diaphragm, cervical cap and spermicidal foam, jelly, cream and sponge; lactational amenorrhea method [LAM]; emergency contraception; and other modern methods not reported separately, e.g. contraceptive patch or vaginal ring)

Advanced

- Breastfeeding status
- Marital status
- Socioeconomic status
- Age (10–14, 15–17, 18–19, 20–24, 25–29, 30–34, 35–39, 40–44 ,45–49, 50+)
- New/repeat user
- Education level

MATURITY LEVEL

B.

Longitudinal follow-up is necessary.

FREQUENCY

Monthly.

DIGITALIZATION

If women can be tracked with a unique identifier, the number of women can be automatically calculated and reported each month. Alerts can be set for each method when it needs to be renewed.

Disaggregation can be automatic, especially for age, geographic area, new or repeat user, marital status, socioeconomic status and education level, if feasible to report.

The type of modern method should be a preset menu with available options for CHWs, and can also capture stock-out.

ALIGNMENT

None.

REFERENCES

1. WHO recommendations: Optimizing health worker roles to improve access to key maternal and newborn health interventions through task shifting. Geneva: WHO; 2012 (https://apps.who.int/iris/bitstream/handle/10665/77764/9789241504843_eng.pdf, accessed 31 August 2020).

26. NUMBER OF WOMEN AND ADOLESCENT GIRLS WHO USE MODERN METHODS FOR FAMILY PLANNING

COMMENT

The details about these interventions should be standardized and indicated when sharing this indicator at national or global level, including the types of modern methods provided.

This mapping is important so that the CHW can see which women – and especially adolescent girls – interrupted their contraception.

CHW TASK

Mapping of the use of modern methods of family planning.

CHW DATA POINTS TO COLLECT

Number of women and adolescent girls who use modern methods

NUMERATOR

Number of women and adolescent girls who use modern methods.

DENOMINATOR

None.

DISAGGREGATION

Basic

- Age (10-14, 15-19, 20-24, 25-49, 50+)
- Geographic area
- Type of modern method distributed/administered (disaggregating by type of modern methods **available in the country**: intrauterine device; implant; injectables; contraceptive pill; male and female condoms; vaginal barrier methods, including the diaphragm, cervical cap and spermicidal foam, jelly, cream and sponge); LAM; emergency contraception; and other modern methods not reported separately, e.g. the contraceptive patch or vaginal ring)

Advanced

- Marital status
- Socioeconomic status
- New/repeat user
- Age (10–14, 15–17, 18–19, 20–24, 25–29, 30–34, 35–39, 40–44 ,45–49, 50+)
- Education level

MATURITY LEVEL

B.

Longitudinal follow-up is necessary.

FREQUENCY

Monthly

DIGITALIZATION

If women and adolescent girls can be tracked with a unique identifier, the number of women and adolescent girls can be automatically calculated and reported each month. Alerts can be set for each method when it needs to be renewed.

Disaggregation can be automatic, especially for age, geographic area, new or repeat user, marital status, socioeconomic status and education level, if feasible to report.

The type of modern method should be a preset menu with available options for CHWs, and can also capture stock-out.

ALIGNMENT

WHO 100 indicators: Contraceptive prevalence – use of modern methods *(1)*

REFERENCES

1. 2018 global reference list of 100 core health indicators (plus health-related SDGs). Geneva: WHO; 2018 (https://apps.who.int/iris/bitstream/handle/10665/259951/WHO-HIS-IER-GPM-2018.1-eng.pdf, accessed 31 August 2020).

27. PROPORTION OF ADOLESCENTS AND YOUNG PEOPLE SEEKING CONTRACEPTION/FAMILY PLANNING WHO RECEIVED AN HIV TEST

COMMENT

Adolescents and young people seeking contraceptive/family planning services often engage in unprotected sexual intercourse, which puts them at risk for HIV infection in high HIV burden and incidence settings (for example, in southern Africa, where HIV incidence is particularly high among adolescent girls and young women). The Evidence for Contraceptive Options in HIV Outcomes (ECHO) trial showed a high incidence of HIV infection among all women seeking contraception, especially women under 25 years. In high HIV burden and incidence settings such as southern Africa, programmes should strengthen the integration of HIV prevention with contraceptive and other sexual and reproductive health services. HIV testing serves as a first step in linkage to antiretroviral therapy (ART) for those testing positive for HIV and to condom promotion and, where appropriate, pre-exposure prophylaxis (PrEP) for those testing negative for HIV. This indicator measures the integration of HIV testing with sexual and reproductive health services by assessing the extent to which adolescents and young people seeking contraception are tested for HIV. Journey from rapid testing to referral, confirmation, results feedback and treatment should be clearly mapped, articulated, funded and integrated into the health system. After disaggregating by gender, this indicator is aligned with the GW.1 indicator of the WHO 2020 Consolidated HIV strategic information guidelines (1).

The intended focus of this indicator is adolescents and young people, ages 10–24 years, assessed by reviewing results by 5-year age bands up to the age of 24 years. The broader inclusion of men and women of reproductive age over the age of 25 serves as a comparison to identify trends among adolescents and young people.

Countries may also need to record which service delivery points can offer integrated services between HIV testing and family planning.

In settings with robust electronic health information systems (for example, with electronic medical records), referral to/uptake of prevention (for example, of PrEP) and treatment services that may reduce new infections could be articulated.

CHW TASK

Offer and conduct rapid HIV testing for adolescents and young people seeking contraception/family planning services.

CHW DATA POINTS TO COLLECT

- Number of adolescents and young people seeking contraception/family planning services who were tested for HIV.
- Number of adolescents and young people seeking contraception/family planning services.

NUMERATOR

Number of adolescents and young people seeking contraception/family planning services who were tested for HIV by CHW.

DENOMINATOR

Number of adolescents and young people seeking contraception/family planning services from CHW.

DISAGGREGATION

Basic

- Gender (male, female, transgender)
- Age (10–14, 15–19, 20–24, 25–49, 50+)
- Geographic area
- HIV test status (negative, positive, indeterminate)

Advanced

- None

MATURITY LEVEL

C.

Longitudinal follow-up is necessary as well as interoperability of records between referral structures for HIV status.

FREQUENCY

Monthly

DIGITALIZATION

None.

ALIGNMENT

WHO consolidated HIV strategic information guidelines *(1)*

REFERENCES

1. Consolidated HIV strategic information guidelines: driving impact through programme monitoring and management. Geneva: World Health Organization; 2020 (https://apps.who.int/iris/bitstream/handle/10665/331697/9789240000735-eng.pdf, accessed 31 August 2020).

28. NUMBER OF HIV TESTS CONDUCTED (TESTING VOLUME) AND THE PROPORTION OF HIV-POSITIVE RESULTS RETURNED TO PEOPLE (POSITIVITY)

COMMENT

This indicator measures HIV test volume and positivity across service delivery approaches and populations. Knowing the numbers of tests conducted annually by testing approach is critical to commodity forecasting and staff resource planning. Testing volume disaggregated by age, sex, testing approach and HIV status helps to assess the gaps among various settings, contexts and populations, and better target resources. Annual testing volumes and positivity rates are inputs into the UNAIDS model to monitor progress towards the first 95 target – 95% of people living with HIV know their HIV status.

HIV testing services also include children. The UNICEF publication *Working to end AIDS for every child (1)* stresses that both HIV testing and treatment rates for children and adolescents are lagging well behind those for adults. For children living with HIV, nearly half do not receive treatment, while others receive it too late. In the context of the UNAIDS 90-90-90 target *(2)*, HIV testing should be routinely offered in child-focused programmes. If the mother is HIV positive and the child continues to be exposed to HIV through breastfeeding, the testing should be done six weeks after cessation of breastfeeding.

The numerator and denominator can be broken down as two indicators for ease of collection and use for CHWs, but they should both be collected to align with WHO 2020 *Consolidated HIV strategic information guidelines (3)* indicator TL.2.

CHW TASK

HIV rapid diagnostic testing.

CHW DATA POINTS TO COLLECT

- Number of tests conducted in which a new HIV-positive result or diagnosis was returned to a person during the reporting period (positivity).
- Number of tests performed where results were returned to a person during the reporting period (testing volume).

NUMERATOR

Number of tests conducted in which a new HIV-positive result or diagnosis was returned to a person during the reporting period (positivity).

DENOMINATOR

Number of tests performed where results were returned to a person during the reporting period (testing volume).

DISAGGREGATION

Basic

- Gender (male, female, transgender)
- Age (0–4, 5–9, 10–14, 15–19, 20–24, 25–29, 30–34, 35–39, 40–44, 45–49, 50+)
- Population: key populations (men who have sex with men, people living in prisons and other closed settings, persons who inject drugs, sex workers, transgender people)
- Tuberculosis (TB) status (presumptive TB, diagnosed TB, none)
- Time to start ART (within 14, 30 or 90 days of diagnosis, as per country guidelines).
- Geographic area

Advanced

- Socioeconomic status (wealth quintile)
- Main caregiver's education level

MATURITY LEVEL

C.

Longitudinal follow-up is necessary as well as interoperability of records between referral structures for HIV status.

FREQUENCY

Monthly

DIGITALIZATION

None.

ALIGNMENT

WHO Consolidated strategic information guidelines for HIV in the health sector: People with HIV *(3)*

REFERENCES

1. For every child, end AIDS: seventh stocktaking report. New York: UNICEF; 2016 (https://www.unicef.org/publications/index_93427.html, accessed 31 August 2020).
2. 90-90-90: Treatment for all. In: UNAIDS [website] (https://www.unaids.org/en/resources/909090, accessed 31 August 2020).
3. Consolidated HIV strategic information guidelines: driving impact through programme monitoring and management. Geneva: World Health Organization; 2020 (https://apps.who.int/iris/bitstream/handle/10665/331697/9789240000735-eng.pdf, accessed 31 August 2020).

Other

Global health sector strategy on HIV 2016–2021: towards ending AIDS. Geneva: WHO; 2016 (https://apps.who.int/iris/bitstream/handle/10665/246178/WHO-HIV-2016.05-eng.pdf, accessed 31 August 2020).

29. MEN AND ADOLESCENT BOYS WITH URETHRAL DISCHARGE

COMMENT

Cultural barriers related to gender culture may impede the reporting of this indicator. These barriers may have to be evaluated and taken into account/addressed for this indicator to be feasible, in order to obtain good data quality.

CHW TASK

STI reporting and referral.

CHW DATA POINTS TO COLLECT

Number of men and adolescent boys reported with urethral discharge during the reporting period.

NUMERATOR

Number of men and adolescent boys reported with urethral discharge.

DENOMINATOR

Number of men and adolescent boys 10 years and older.

DISAGGREGATION

Basic

- Age (10–14, 15–19, 20+)
- Geographic area
- Referral

Advanced

- Age (10–14, 15–17, 18–19, 20–24, 25–29, 30–34, 35–39, 40–44, 45–49, 50+)

MATURITY LEVEL

A.

FREQUENCY

Monthly.

DIGITALIZATION

None.

ALIGNMENT

Global AIDS Monitoring 2020: Men with urethral discharge *(1)*

REFERENCES

1. Global AIDS Monitoring 2020: indicators for monitoring the 2016 Declaration on Ending AIDS. Geneva: UNAIDS; 2019 (https://www.unaids.org/sites/default/files/media_asset/global-aids-monitoring_en.pdf, accessed 31 August 2020).

30. PROPORTION OF ANTENATAL CARE ATTENDEES TESTED FOR SYPHILIS

COMMENT

Rapid treponemal tests (sometimes combined with HIV rapid tests) can be provided for CHWs to screen pregnant women for syphilis during the first ANC contact, with corresponding training and supervision. Longitudinal follow-up of pregnant women is also necessary. STIs in pregnant women, including active syphilis, have the potential to cause serious morbidity and mortality among exposed newborns. This indicator measures the extent of routine syphilis screening by CHWs among pregnant women at first visit (ideally) or at any antenatal care visit.

It is critical to confirm positive rapid tests at the facility level.

CHW TASK

Rapid test for syphilis during first CHW antenatal care contact and referral if test is positive for confirmation and treatment.

CHW DATA POINTS TO COLLECT

- Number of women attending ANC services provided by CHW during the reporting period who were tested for syphilis.
- Number of women attending ANC services provided by CHW during the reporting period.

NUMERATOR

Number of women attending ANC services provided by CHW during the reporting period who were tested for syphilis.

DENOMINATOR

Number of women attending ANC services provided by CHW during the reporting period.

DISAGGREGATION

Basic

- Age (10–14, 15–19, 20+)
- Visit at which testing was done (first ANC visit, other than first ANC visit during the current pregnancy)
- Geographic area

Advanced

- Age (10–14, 15–17, 18–19, 20–24, 25–29, 30–34, 35–39, 40–44, 45–49, 50+)

MATURITY LEVEL

C.

Longitudinal follow-up is necessary and data exchange with facility to ensure there is no double counting.

FREQUENCY

Monthly.

DIGITALIZATION

None.

ALIGNMENT

WHO 100 indicators: Congenital syphilis rate *(1)*

Global Strategy for Women's, Children's and Adolescents' Health: Percentage of women accessing antenatal care (ANC) services who were tested for syphilis (any visit) *(2)*

HDC facility guidance: Reproductive, maternal, newborn, child and adolescent health and nutrition (RMNCAH): Antenatal client syphilis screening *(3)*

Global AIDS Monitoring 2020: Congenital syphilis rate *(4)*

REFERENCES

1. 2018 global reference list of 100 core health indicators (plus health-related SDGs). Geneva: WHO; 2018 (https://apps.who.int/iris/bitstream/handle/10665/259951/WHO-HIS-IER-GPM-2018.1-eng.pdf, accessed 31 August 2020).
2. Global Health Observatory (GHO) Data [online database]. Global Strategy for Women's, Children's and Adolescents' Health (2016–2030): Data portal. In: World Health Organization [website] (https://www.who.int/gho/publications/gswcah_portal/en/, accessed 31 August 2020).
3. Analysis and use of health facility data: guidance for RMNCAH programme managers. Working Document. October 2019. Geneva: World Health Organization; 2019 (https://www.who.int/healthinfo/FacilityAnalysisGuidance_RMNCAH.pdf, accessed 31 August 2020).
4. Global AIDS Monitoring 2020: indicators for monitoring the 2016 Declaration on Ending AIDS. Geneva: UNAIDS; 2019 (https://www.unaids.org/sites/default/files/media_asset/global-aids-monitoring_en.pdf, accessed 31 August 2020).

Other

Consolidated HIV strategic information guidelines: driving impact through programme monitoring and management. Geneva: World Health Organization; 2020 (https://apps.who.int/iris/bitstream/handle/10665/331697/9789240000735-eng.pdf, accessed 31 August 2020).

31. PROPORTION OF WOMEN WHO HAVE BEEN SCREENED FOR CERVICAL CANCER

COMMENT

Journey from screening to referral, results feedback and eventual procedures should be clearly mapped, articulated, funded and integrated in the health system (including recommended frequency of screening).

The disaggregation by HIV status is key and is aligned with the ST.3 indicator of the WHO *Consolidated HIV strategic information guidelines (1)*.

For women living with HIV, screening may need to occur earlier than for other women.

CHW TASK

Follow-up to ensure every woman had a screening test for cervical cancer according to national policy.

CHW DATA POINTS TO COLLECT

Number of women who had a screening test for cervical cancer according to national policy.

NUMERATOR

Number of women who had a screening test for cervical cancer according to national policy.

DENOMINATOR

Number of women who should have had a screening test according to national policy.

DISAGGREGATION

Basic

- At least one screening test in their life
- Age (10–14, 15–19, 20–24, 25–29, 30–49, 50+)
- Geographic area
- HIV status

Advanced

- Socioeconomic status (wealth quintile)
- Education level

MATURITY LEVEL

B.

Longitudinal follow-up is necessary.

Interoperability of information is needed for advanced disaggregation by HIV status.

FREQUENCY

At least once a year if reported by household assessment.

DIGITALIZATION

None.

ALIGNMENT

WHO 100 indicators: Cervical cancer screening *(1)*

2020 WHO Consolidated HIV strategic information guidelines *(2)*

REFERENCES

1. Consolidated HIV strategic information guidelines: driving impact through programme monitoring and management. Geneva: World Health Organization; 2020 (https://apps.who.int/iris/bitstream/handle/10665/331697/9789240000735-eng.pdf, accessed 31 August 2020).
2. 2018 global reference list of 100 core health indicators (plus health-related SDGs). Geneva: WHO; 2018 (https://apps.who.int/iris/bitstream/handle/10665/259951/WHO-HIS-IER-GPM-2018.1-eng.pdf, accessed 31 August 2020).

Other

Consolidated HIV strategic information guidelines: driving impact through programme monitoring and management. Geneva: World Health Organization; 2020 (https://apps.who.int/iris/bitstream/handle/10665/331697/9789240000735-eng.pdf, accessed 31 August 2020).

32. NUMBER OF WOMEN REFERRED FOR ANY POST-ABORTION COMPLICATION

COMMENT

Each year, between 4.7% and 13.2% of maternal deaths can be attributed to unsafe abortion. Around 7 million women are admitted to hospitals every year in developing countries as a result of unsafe abortion. Almost every abortion death and disability could be prevented through sexuality education; use of effective contraception; provision of safe, legal induced abortion; and timely care for complications.

CHW TASK

Refer women for any post-abortion complication.

CHW DATA POINTS TO COLLECT

Number of women referred for any post-abortion complication.

NUMERATOR

Number of women referred for any post-abortion complication.

DENOMINATOR

None.

DISAGGREGATION

Basic

- Age (10–14, 15–19, 20+)
- Geographic area

Advanced

- Age (10–14, 15–17, 18–19, 20–24, 25–29, 30–34, 35–39, 40–44, 45–49, 50+)
- Socioeconomic status (wealth quintile)
- Education level

MATURITY LEVEL

A.

FREQUENCY

Monthly.

DIGITALIZATION

None.

ALIGNMENT

WHO 100 indicators: Obstetric and gynaecological admissions owing to abortion *(1)*

HDC facility guidance: RMNCAH: Gynaecology abortion care *(2)*

REFERENCES

1. 2018 global reference list of 100 core health indicators (plus health-related SDGs). Geneva: WHO; 2018 (https://apps.who.int/iris/bitstream/handle/10665/259951/WHO-HIS-IER-GPM-2018.1-eng.pdf, accessed 31 August 2020).
2. Analysis and use of health facility data: guidance for RMNCAH programme managers. Working Document. October 2019. Geneva: World Health Organization; 2019 (https://www.who.int/healthinfo/FacilityAnalysisGuidance_RMNCAH.pdf, accessed 31 August 2020).

Other

Preventing unsafe abortion: key facts. 26 June 2019. In: World Health Organization [website] (https://www.who.int/news-room/fact-sheets/detail/preventing-unsafe-abortion, accessed 31 August 2020).

New estimates show worldwide fall in unintended pregnancies since 1990–1994. 23 July 2020. In: World Health Organization [website] (https://www.who.int/news-room/detail/23-07-2020-new-estimates-show-worldwide-fall-in-unintended-pregnancies-since-1990-1994, accessed 31 August 2020).

33. NUMBER OF WOMEN REFERRED FOR SAFE ABORTION

COMMENT

In countries where safe abortion is legal, CHWs can refer women for safe abortion.

CHW TASK

Refer women for safe abortion.

CHW DATA POINTS TO COLLECT

Number of women referred for safe abortion.

NUMERATOR

Number of women referred for safe abortion.

DENOMINATOR

None.

DISAGGREGATION

Basic

- Age (10–14, 15–19, 20+)
- Geographic area

Advanced

- Socioeconomic status (wealth quintile)
- Education level
- Age (10–14, 15–17, 18–19, 20–24, 25–29, 30–34, 35–39, 40–44, 45–49, 50+)

MATURITY LEVEL

B.

FREQUENCY

Monthly

DIGITALIZATION

None.

ALIGNMENT

WHO 100 indicators: Obstetric and gynaecological admissions owing to abortion *(1)*

HDC facility guidance: RMNCAH: Gynaecology abortion care *(2)*

REFERENCES

1. 2018 global reference list of 100 core health indicators (plus health-related SDGs). Geneva: WHO; 2018 (https://apps.who.int/iris/bitstream/handle/10665/259951/WHO-HIS-IER-GPM-2018.1-eng.pdf, accessed 31 August 2020).
2. Analysis and use of health facility data: guidance for RMNCAH programme managers. Working Document. October 2019. Geneva: World Health Organization; 2019 (https://www.who.int/healthinfo/FacilityAnalysisGuidance_RMNCAH.pdf, accessed 31 August 2020).

Other

Preventing unsafe abortion: key facts. 26 June 2019. In: World Health Organization [website] (https://www.who.int/news-room/fact-sheets/detail/preventing-unsafe-abortion, accessed 31 August 2020).

New estimates show worldwide fall in unintended pregnancies since 1990–1994. 23 July 2020. In: World Health Organization [website] (https://www.who.int/news-room/detail/23-07-2020-new-estimates-show-worldwide-fall-in-unintended-pregnancies-since-1990-1994, accessed 31 August 2020).

34. NUMBER/PROPORTION OF WOMEN AGED 15–49 YEARS OLD WHO HAVE UNDERGONE FEMALE GENITAL MUTILATION

COMMENT

Female genital mutilation (FGM) refers to all procedures involving partial or total removal of the external female genitalia or other injury to the female genital organs for non-medical reasons. FGM has no known health benefits and can lead to health consequences in the short term and over the life-course. FGM is recognized internationally as a violation of the human rights of girls and women. It reflects deep-rooted inequality between the sexes, and constitutes an extreme form of discrimination against women. It is nearly always carried out on minors and is a violation of the rights of children. The practice also violates a person's rights to health, security and physical integrity; the right to be free from torture and cruel, inhuman or degrading treatment; and the right to life when the procedure results in death.

Prevalence data on FGM are captured in household surveys using a standardized module in the Demographic and Health Surveys and the Multiple Indicator Cluster Surveys in over 30 countries. The purpose of CHWs collecting data on FGM would be to identify at-risk households for targeted prevention efforts and to ensure that health complications due to FGM are properly managed. **Girls under age 15 who are in households in which the mother or older sisters have already undergone FGM are at high risk of undergoing FGM**.

CHW TASK

Identification of households where girls are at risk of undergoing FGM because their mother or older sisters have undergone the practice.

Identification of households where women and girls who have undergone FGM are at risk of and/or are suffering from health complications.

CHW DATA POINTS TO COLLECT

Number of women aged 15–49 years old who have undergone FGM.

NUMERATOR

Number of women aged 15–49 years old who have undergone FGM.

DENOMINATOR

Number of women aged 15–49 years old in the catchment area.

DISAGGREGATION

Basic

- Geographic area
- Age (15–19, 20+)

Advanced

- FGM type
- Age (15–17, 18–19, 20–24, 25–29, 30–34, 35–39, 40–44, 45–49)
- Socioeconomic status
- Education level

MATURITY LEVEL

B.

FREQUENCY

At least once a year.

DIGITALIZATION

Disaggregation can be automatic for the geographic area, education level and socioeconomic status, if the information is already collected with a personal identifier

ALIGNMENT

SDG: 5.3.2: Proportion of girls and women aged 15–49 who have undergone FGM/cutting *(1)*

WHO 100 indicators: Prevalence of female genital mutilation/cutting *(2)*

Global Strategy for Women's, Children's and Adolescents' Health: Proportion of girls and women aged 15–49 years who have undergone female genital mutilation/cutting (FMG/C) (%) *(3)*

HDC facility guidance: RMNCAH: Female genital mutilation *(4)*

REFERENCES

1. Sustainable Development Goals. SDG indicators metadata repository. In: United Nations Statistics Division [website] (https://unstats.un.org/sdgs/metadata/, accessed 31 August 2020).
2. Global Health Observatory (GHO) Data [online database]. Global Strategy for Women's, Children's and Adolescents' Health (2016–2030): Data portal. In: World Health Organization [website] (https://www.who.int/gho/publications/gswcah_portal/en/, accessed 31 August 2020).
3. 2018 global reference list of 100 core health indicators (plus health-related SDGs). Geneva: WHO; 2018 (https://apps.who.int/iris/bitstream/handle/10665/259951/WHO-HIS-IER-GPM-2018.1-eng.pdf, accessed 31 August 2020).
4. Analysis and use of health facility data: guidance for RMNCAH programme managers. Working Document. October 2019. Geneva: World Health Organization; 2019 (https://www.who.int/healthinfo/FacilityAnalysisGuidance_RMNCAH.pdf, accessed 31 August 2020).

Other

Care of girls and women with female genital mutilation: a clinical handbook. Geneva: World Health Organization; 2018 (https://www.who.int/reproductivehealth/publications/health-care-girls-women-living-with-FGM/en/, accessed 31 August 2020).

WHO guidelines on the management of health complications from female genital mutilation. Geneva: World Health Organization; 2016 (https://www.who.int/reproductivehealth/topics/fgm/management-health-complications-fgm/en/, accessed 31 August 2020).

Eliminating female genital mutilation: an interagency statement – OHCHR, UNAIDS, UNDP, UNECA, UNESCO, UNFPA, UNHCR, UNICEF, UNIFEM, WHO. Geneva: World Health Organization; 2008 (https://www.who.int/reproductivehealth/publications/fgm/9789241596442/en/, accessed 31 August 2020).

35. PROPORTION OF PREGNANT WOMEN WHO HAVE FIRST ANTENATAL CARE (ANC) CONTACT WITH CHW IN FIRST TRIMESTER

COMMENT

This indicator should be reported by CHW only if they do the first antenatal care (ANC) and are trained and supervised to count weeks of amenorrhea.

CHW TASK

ANC contact.

CHW DATA POINTS TO COLLECT

- Number of pregnant women who have first ANC contact during first trimester by CHW (less than 12 weeks).
- Number of pregnant women who have at least one ANC contact.

NUMERATOR

Number of pregnant women who have first ANC contact with CHW during first trimester (less than 12 weeks).

DENOMINATOR

Number of pregnant women who have at least one ANC contact with CHW.

DISAGGREGATION

Basic

- Age (10–14, 15–19, 20+)
- Geographic area

Advanced

- ANC contact (weeks amenorrhea)
- Age (10–14, 15–17, 18–19, 20–24, 25–29, 30–34, 35–39, 40–44, 45–49, 50+)
- Number of gestations plus parity

MATURITY LEVEL

B.

Longitudinal follow-up is critical to know which contact is first.

FREQUENCY

Monthly.

DIGITALIZATION

Disaggregation can be automatic, especially for age, geographic area and number of gestations plus parity, if feasible to report.

ALIGNMENT

HDC facility guidance: RMNCAH: ANC client first visit before 12 weeks' gestation.

REFERENCES

1. Analysis and use of health facility data: guidance for RMNCAH programme managers. Working Document. October 2019. Geneva: World Health Organization; 2019 (https://www.who.int/healthinfo/FacilityAnalysisGuidance_RMNCAH.pdf, accessed 31 August 2020).

36. PROPORTION OF ANTENATAL CARE CONTACTS DURING WHICH WOMEN RECEIVED BREASTFEEDING COUNSELLING

COMMENT

It is critical that women receive counselling at every ANC contact. When positive, the patient should be referred.

CHW TASK

Provide breastfeeding counselling during the antenatal period focused on early initiation of breastfeeding and the importance of not feeding any food or fluid other than breastmilk.

CHW DATA POINTS TO COLLECT

- Number of community ANC contacts in the reporting period where pregnant women received any breastfeeding counselling.
- Total number of community ANC contacts in the reporting period.

NUMERATOR

Number of community ANC contacts in the reporting period where pregnant women received any breastfeeding counselling.

DENOMINATOR

Total number of community ANC contacts in the reporting period.

DISAGGREGATION

Basic

- Geographic area

Advanced

- None

MATURITY LEVEL

A.

FREQUENCY

Monthly.

DIGITALIZATION

Content of counselling can be a preset menu and calculation can be automated to assess an additional indicator about timely and appropriate counselling.

ALIGNMENT

HDC Facility guidance: Nutrition: Proportion of women who received breastfeeding counselling during antenatal period [pending publication]

Global Nutrition Monitoring Framework *(1)* [NOTE: Indicators are being revised and should include one on counselling]

REFERENCES

1. Global Nutrition Monitoring Framework: operational guidance for tracking progress in meeting targets for 2025. Geneva: World Health Organization; 2017 (https://www.who.int/publications/i/item/9789241513609, accessed 31 August 2020).

Other

Guideline: counselling of women to improve breastfeeding practices. Geneva: World Health Organization; 2018 (https://apps.who.int/iris/bitstream/handle/10665/280133/9789241550468-eng.pdf, accessed 31 August 2020).

37. PROPORTION OF COMMUNITY ANTENATAL CARE CONTACTS IN THE REPORTING PERIOD DURING WHICH PREGNANT WOMEN WERE GIVEN/PRESCRIBED IRON-CONTAINING SUPPLEMENTS

COMMENT

WHO Recommendation A.2.1: Daily oral iron and folic acid supplementation with 30 to 60 milligrams (mg) of elemental iron and 400 micrograms (µg) (0.4 mg) folic acid is recommended for pregnant women to prevent maternal anaemia, puerperal sepsis, low birthweight and preterm birth.

WHO suggests that CHWs be considered for providing this supplementation in the context of targeted monitoring and evaluation.

CHW TASK

Provision of iron-containing supplements during community ANC contacts.

CHW DATA POINTS TO COLLECT

- Number of community ANC contacts in the reporting period during which pregnant women were given/ prescribed iron-containing supplements. This can also include women who already had enough supplements until the next contact from a previous contact, as might occur in countries where more than a one-month supply is given at each visit (e.g. in some countries a three-month supply is given at first ANC contact).
- Total number of community ANC contacts in the reporting period.

NUMERATOR

Number of community ANC contacts in the reporting period during which pregnant women were given/ prescribed iron-containing supplements.

DENOMINATOR

Total number of community ANC contacts in the reporting period.

DISAGGREGATION

Basic

- Geographic area

Advanced

- When recording/reporting is digitized
- Age
- Type of supplementation (iron and folic acid supplements [IFA], multiple micronutrient supplements or powders, iron-only supplements, etc.)

MATURITY LEVEL

A.

FREQUENCY

Monthly.

DIGITALIZATION

If women can be tracked with a unique identifier, a separate indicator of "proportion of registered pregnant women who came to term in the reporting period who received or were prescribed at least 90 iron-containing supplements throughout their entire pregnancy" is recommended, but via health facility tracking where longitudinal registers are used. However, if a system is fully digitized with unique IDs, the CHW could record receipt/prescription of iron-containing supplements on specific dates per unique ID to automatically tally in the system with health facility data. Alerts can be set for women who need to get additional supplements or prescriptions. With digitalization and unique IDs, it would also be possible to report on the percentage of pregnant women who received their first supplements during their first trimester.

ALIGNMENT

Global Nutrition Monitoring Framework *(1)* [NOTE: Indicators are being revised and should include revision to the one on supplementation of pregnant women with iron-containing supplements].

REFERENCES

1. Global Nutrition Monitoring Framework: operational guidance for tracking progress in meeting targets for 2025. Geneva: World Health Organization; 2017 (https://www.who.int/publications/i/item/9789241513609, accessed 31 August 2020).

Other

WHO recommendations on antenatal care for a positive pregnancy experience 2016. Geneva: World Health Organization; 2016 (https://apps.who.int/iris/bitstream/handle/10665/250796/9789241549912-eng.pdf, accessed 31 August 2020).

WHO recommendations: optimizing health worker roles to improve access to key maternal and newborn health interventions through task shifting. Geneva: World Health Organization; 2012 (https://apps.who.int/iris/bitstream/handle/10665/77764/9789241504843_eng.pdf, accessed 31 August 2020).

e-Library of Evidence for Nutrition Actions (eLENA): Daily iron and folic acid supplementation during pregnancy. In: World Health Organization [website] (https://www.who.int/elena/titles/daily_iron_pregnancy/en/, accessed 31 August 2020).

e-Library of Evidence for Nutrition Actions (eLENA): Daily iron and folic acid supplementation during pregnancy. Guidance summary. In: World Health Organization [website] (https://www.who.int/elena/titles/guidance_summaries/daily_iron_pregnancy/en/, accessed 31 August 2020).

38. PROPORTION OF PEOPLE WITH RAISED BLOOD PRESSURE MEASURED BY CHW

COMMENT

Proper training is needed to ensure quality of measurement and data reporting (systolic and diastolic measures).

CHW TASK

Blood pressure measurement.

CHW DATA POINTS TO COLLECT

Number of people with measured raised blood pressure (systolic blood pressure ≥ 140 or diastolic blood pressure ≥ 90).

NUMERATOR

Number of people with measured raised blood pressure (systolic blood pressure ≥ 140 or diastolic blood pressure ≥ 90).

DENOMINATOR

Number of people in the catchment area.

DISAGGREGATION

Basic

- Age (10-14, 15-19, 20-29, 30-49, 50+)
- Sex
- Geographic area
- Referral

Advanced

- On treatment for raised blood pressure
- Socioeconomic status (wealth quintile)

MATURITY LEVEL

C.

Longitudinal follow-up is necessary as well as interoperability of records between structures.

FREQUENCY

Monthly.

DIGITALIZATION

If people can be tracked with a unique identifier, the number of people identified can be automatically reported each month. Interoperability with the facility is also critical so data can be reconciled to avoid double counting. It is also critical to follow up on the blood pressure after the pregnancy to determine if it becomes chronic (in which case treatment may be needed) or not (an alert can be set for the next pregnancy).

Disaggregation can be automatic, especially for age, sex, geographic area, pregnancy status and socioeconomic status, if feasible.

ALIGNMENT

HDC facility guidance: RMNCAH: Antenatal client blood pressure measurement, Blood pressure measurement during third trimester *(1)*

NCD Global Monitoring Framework: age-standardized prevalence of raised blood pressure among persons aged 18+ years and mean systolic blood pressure *(2)*

REFERENCES

1. Analysis and use of health facility data: guidance for RMNCAH programme managers. Working Document. October 2019. Geneva: World Health Organization; 2019 (https://www.who.int/healthinfo/FacilityAnalysisGuidance_RMNCAH.pdf, accessed 31 August 2020).
2. NCD Global Monitoring Framework. In: World Health Organization [website] (https://www.who.int/nmh/global_monitoring_framework/en/, accessed 31 August 2020).

39. NUMBER OF PREGNANT WOMEN REFERRED FOR MATERNAL COMPLICATIONS

CHW TASK

Referral for maternal complication.

CHW DATA POINTS TO COLLECT

Number of pregnant women referred for maternal complications.

NUMERATOR

Number of pregnant women referred for maternal complications.

DENOMINATOR

None.

DISAGGREGATION

Basic

- Age (age groups 10–14, 15–19, 20+)
- Geographic area
- Antenatal care, Labor and delivery, Postpartum

Advanced

- Age (10–14, 15–19, 20+)
- Maternal death
- Newborn death
- Socioeconomic status (wealth quintile)
- Maternal education

MATURITY LEVEL

A.

FREQUENCY

Monthly.

DIGITALIZATION

If women and adolescent girls can be tracked with a unique identifier and there is interoperability with the facility dataset, the diagnostic and outcome for the mother and newborn can be reported.

Disaggregation can be automatic, especially for age, sex, geographic area, number of ANC contacts, number of gestations plus parity, education level and socioeconomic status, if feasible. The reason for referral should be presented in a preset menu.

ALIGNMENT

None.

REFERENCES

None.

40. PROPORTION OF WOMEN WHO GAVE BIRTH IN THE COMMUNITY WITHOUT SKILLED BIRTH ATTENDANT AND WHO WERE ADMINISTERED ORAL IMMEDIATE POSTPARTUM UTEROTONIC TO PREVENT POSTPARTUM HAEMORRHAGE

COMMENT

In settings where skilled birth attendants (SBA) are not present and oxytocin is not available, WHO recommends the administration of **oral** misoprostol (600 µg by mouth) by CHWs for the prevention of postpartum haemorrhage. (Strong recommendation, moderate-quality evidence) *(1)*.

If CHWs have the capacity to use it for community deliveries, the type of oral uterotonic used should be indicated when sharing this indicator at national or global level.

CHW TASK

Administration of immediate oral postpartum uterotonic to prevent postpartum haemorrhage if delivery in the community without SBA.

CHW DATA POINTS TO COLLECT

- Number of women who gave birth in the community without SBA and who were administered oral immediate postpartum uterotonic to prevent postpartum haemorrhage.
- Number of live births delivered in the community.

NUMERATOR

Number of women and adolescent girls who gave birth in the community without SBA and who were administered immediate oral postpartum uterotonic to prevent postpartum haemorrhage.

DENOMINATOR

Number of live births delivered in the community.

DISAGGREGATION

Basic

- Age (age groups 10–14, 15–19, 20+)
- Geographic area
- Type of oral postpartum uterotonic (misoprostol, other)

Advanced

- Age (10–14, 15–17, 18–19, 20–24, 25–29, 30–34, 35–39, 40–44, 45–49, 50+)

MATURITY LEVEL

A.

FREQUENCY

Monthly.

DIGITALIZATION

The type of oral postpartum uterotonic available to CHWs should be presented with a preset menu.

Disaggregation can be automatic, especially for age and geographic area.

ALIGNMENT

HDC facility guidance: RMNCAH: Uterotonic for prevention of postpartum haemorrhage *(2)*

REFERENCES

1. WHO recommendations: Optimizing health worker roles to improve access to key maternal and newborn health interventions through task shifting. Geneva: World Health Organization; 2012 (https://apps.who.int/iris/bitstream/handle/10665/77764/9789241504843_eng.pdf, accessed 31 August 2020).
2. Analysis and use of health facility data: guidance for RMNCAH programme managers. Working Document. October 2019. Geneva: World Health Organization; 2019 (https://www.who.int/healthinfo/FacilityAnalysisGuidance_RMNCAH.pdf, accessed 31 August 2020).

41. NUMBER/PROPORTION OF PEOPLE ASSESSED FOR MENTAL, NEUROLOGICAL AND SUBSTANCE USE (MNS) DISORDERS

COMMENT

Mental, neurological and substance use (MNS) disorders are the leading cause of disability and lead to significant health, social, human rights and economic consequences in all countries around the world. Approximately half of all mental health conditions start by age 14, and suicide is the second leading cause of death in young people aged 15–29. The majority of people with MNS disorders receive no treatment for their condition, despite the evidence that effective interventions can be delivered in any resource context.

MNS disorders refer here to the following priority conditions identified in WHO's mental health Gap Action Programme (mhGAP): psychosis, depression, bipolar disorder, epilepsy, developmental disorders, behavioural disorders, dementia, alcohol use disorder, drug use disorders, suicide/self-harm. These conditions are therefore proposed as tracer conditions.

Maternal mental health is a key determinant of early child development. Assessment, referral and treatment of mental health conditions in pregnant and postpartum women and adolescent girls is essential for achieving universal health coverage (UHC) and Sustainable Development Goals (SDGs). The early stages of life present a particularly important opportunity to promote mental health and prevent mental disorders. Since up to 50% of mental disorders begin before the age of 14 years, data disaggregation by age and specifically for adolescents is crucial.

Likewise, mental health conditions are common in people with HIV, TB, or neglected tropical diseases (NTDs), and have an impact on their outcomes. For example, most NTDs can lead to depression as a result of stigmatization and/or disabilities; some can also cause epilepsy (e.g. neurocysticercosis) or dementia (e.g. sleeping sickness). Monitoring mental health and well-being for these populations is therefore a necessity.

WHO has published the mhGAP community toolkit *(1)* that can be used as a reference tool for the assessment of MNS disorders/mental health conditions by CHWs.

Confidentiality (see the mhGAP toolkit and section 7.5.4 in the main text of this guidance and parental consent for adolescents according to national policy should be ensured.

CHW TASK

Identify people with MNS disorders/mental health conditions.

CHW DATA POINTS TO COLLECT

Number of people assessed for MNS disorders/mental health conditions.

NUMERATOR

Number of people assessed for MNS disorders/mental health conditions.

DENOMINATOR

Number of people with a possible MNS symptom.

DISAGGREGATION

Basic

- Gender (male, female, transgender)
- Pregnancy, postpartum
- Age (10–14, 15–19, 20+)
- Geographic area
- Type of MNS disorder: Depression, psychoses, epilepsy, child and adolescent mental and behavioural conditions, dementia, substance use conditions, suicide/self-harm
- Sub-populations with comorbid conditions (HIV, TB, NTDs)

Advanced

- Socioeconomic status (wealth quintile)
- Education level
- Age (10–14, 15–19, 20–24, 25–29, 30–34, 35–39, 40–44, 45–49, 50–54, 55–59, 60–64, 65–69, 70–74, 75–79, 80+)

MATURITY LEVEL

B.

FREQUENCY

Monthly.

DIGITALIZATION

Disaggregation can be automatic, especially for age, geographic area, sex, education level and socioeconomic status, if feasible.

ALIGNMENT

SDG *(2)*: The SDGs make specific reference to universal health coverage (UHC) of mental health under target 3.4 (By 2030, reduce by one third premature mortality from noncommunicable diseases through prevention and treatment and promote mental health and well-being).

The SDGs also make specific reference to the prevention and treatment of substance abuse in target 3.5. Alcohol consumption is specifically addressed in SDG indicator 3.5.2 on alcohol consumption: "Alcohol per capita consumption (aged 15 years and older) within a calendar year in litres of pure alcohol".

WHO 100 indicators: Partial; only service coverage for severe mental disorders is included *(3)*

Other:

In 2013, the World Health Assembly implemented the WHO's comprehensive *Mental health action plan 2013–2020 (4)*, which articulated pragmatic guidelines for the delivery of services, especially in low- and middle-income countries (LMICs). The action plan includes the target "service coverage for severe mental disorders will have increased by 20% [by the year 2020]" and the accompanying indicator "the proportion of persons with a severe mental disorder (psychosis, bipolar affective disorder, moderate-severe depression) who are using services". During the Seventy-second World Health Assembly (2019) the period of the action plan was extended to 2030 in order to ensure their alignment with the 2030 Agenda for Sustainable Development.

In 2017, the World Health Assembly adopted the global action plan on the public health response to dementia, outlining key actions and global targets across seven strategic areas. One of these areas aims to increase the diagnostic rate for dementia to at least 50% in at least half of WHO's Member States by 2025 *(5)*.

REFERENCES

1. mhGAP community toolkit: field test version. Geneva: World Health Organization; 2019 (https://www.who.int/publications/i/item/the-mhgap-community-toolkit-field-test-version, accessed 31 August 2020).
2. Sustainable Development Goals. SDG indicators metadata repository. In: United Nations Statistics Division [website] (https://unstats.un.org/sdgs/metadata/, accessed 31 August 2020).
3. 2018 global reference list of 100 core health indicators (plus health-related SDGs). Geneva: WHO; 2018 (https://apps.who.int/iris/bitstream/handle/10665/259951/WHO-HIS-IER-GPM-2018.1-eng.pdf, accessed 31 August 2020).
4. Mental health action plan 2013–2020. Geneva: World Health Organization; 2013 (https://apps.who.int/iris/bitstream/handle/10665/89966/9789241506021_eng.pdf, accessed 31 August 2020)
5. Global action plan on the public health response to dementia 2017–2025. Geneva: World Health Organization; 2017 (https://www.who.int/mental_health/neurology/dementia/action_plan_2017_2025/en/, accessed 31 August 2020).

Other

mhGAP intervention guide for mental, neurological and substance use disorders in non-specialized health settings. Version 2.0. Geneva: World Health Organization; 2016 (https://www.who.int/publications/i/item/mhgap-intervention-guide---version-2.0, accessed 31 August 2020).

Thirteenth General Programme of Work (GPW13) methods for impact measurement. Geneva: World Health Organization; 2020 (https://www.who.int/publications/m/item/thirteenth-general-programme-of-work-(gpw13)-methods-for-impact-measurement, accessed 31 August 2020).

Sustainable Development Goal 3: Health. In: World Health Organization [website] (https://www.who.int/topics/sustainable-development-goals/targets/en/, accessed 31 August 2020).

42. NUMBER/PROPORTION OF PEOPLE WITH MENTAL, NEUROLOGIC AND SUBSTANCE USE (MNS) REFERRED

COMMENT

Mental disorders contribute to 7% of the global burden of diseases and have significant impacts on health and major social, human rights and economic consequences in all countries of the world. Approximately half of all mental disorders start by age 14, and suicide is the second leading cause of death in young people aged 15–29. Yet, often people with mental health conditions receive no treatment for their condition, despite the evidence that effective interventions can be delivered in any resource context.

The proportion of people with MNS disorders referred to mental health services is an indicator for service coverage and is linked to SGD target 3.4 and WHO's comprehensive *Mental health action plan 2013–2030 (1)*.

The early stages of life present a particularly important opportunity to promote mental health and prevent mental disorders. Since up to 50% of mental disorders begin before the age of 14 years, data disaggregation by age and specifically for adolescents is crucial.

Likewise, mental health conditions are common in people with HIV, TB or NTDs. For example, most NTDs can lead to depression as a result of stigmatization and/or disabilities; some can also cause epilepsy (e.g. neurocysticercosis) or dementia (e.g. sleeping sickness). Monitoring mental health and well-being for these populations is therefore a necessity.

WHO has published the mhGAP community toolkit *(2)* that can be used as a reference tool for the assessment of MNS disorders/mental health conditions by CHWs.

Confidentiality (see the mhGAP toolkit and section 7.5.4 in the main text of this guidance) and parental consent for adolescents according to national policy should be ensured.

CHW TASK

Refer people with MNS disorders/mental health conditions to specialist services. Known patients should be reassessed ideally before referral.

CHW DATA POINTS TO COLLECT

Number of people with MNS disorders/mental health conditions who have been referred to specialist services in a given year.

NUMERATOR

Number of people with MNS disorders/mental health conditions who have been referred to specialist services.

DENOMINATOR

Total number of people assessed for MNS disorders/ mental health conditions.

DISAGGREGATION

Basic

- Gender (male, female, transgender)
- Pregnancy, postpartum
- Age (10–14, 15–19, 20+)
- Geographic area
- Type of MNS disorder: Depression, psychoses, epilepsy, child and adolescent mental and behavioural conditions, dementia, substance use conditions, suicide/self-harm
- Sub-populations with comorbid conditions (HIV, TB, NTDs)

Advanced

- Socioeconomic status (wealth quintile)
- Education level
- Age (10–14, 15–19, 20–24, 25–29, 30–34, 35–39, 40–44, 45–49, 50–54, 55–59, 60–64, 65–69, 70–74, 75–79, 80+)

MATURITY LEVEL

B/C.

FREQUENCY

Monthly.

DIGITALIZATION

Disaggregation can be automatic, especially for age, geographic area, sex, education level and socioeconomic status, if feasible.

ALIGNMENT

SDG *(3)*: The SDGs make specific reference to UHC of mental health under target 3.4 (By 2030, reduce by one third premature mortality from noncommunicable diseases through prevention and treatment and promote mental health and well-being).

The SDGs also make specific reference to the prevention and treatment of substance abuse in target 3.5. Alcohol consumption is specifically addressed in SDG indicator 3.5.2 on alcohol consumption: "Alcohol per capita consumption (aged 15 years and older) within a calendar year in litres of pure alcohol".

WHO 100 indicators: Partial; only service coverage for severe mental disorders is included *(4)*

Other:

In 2013, the World Health Assembly implemented the WHO's comprehensive Mental health action plan 2013–2020 (1), which articulated pragmatic guidelines for the delivery of services, especially in low- and middle-income countries (LMICs). The action plan includes the target "service coverage for severe mental disorders will have increased by 20% [by the year 2020]" and the accompanying indicator "the proportion of persons with a severe mental disorder (psychosis, bipolar affective disorder, moderate-severe depression) who are using services". During the Seventy-second World Health Assembly (2019) the period of the action plan was extended to 2030 in order to ensure their alignment with the 2030 Agenda for Sustainable Development.

In 2017, the World Health Assembly adopted the global action plan on the public health response to dementia, outlining key actions and global targets across seven strategic areas. One of these areas aims to increase the diagnostic rate for dementia to at least 50% in at least half of WHO's Member States by 2025 *(5)*.

REFERENCES

1. Mental health action plan 2013–2020. Geneva: World Health Organization; 2013 (https://apps.who.int/iris/bitstream/handle/10665/89966/9789241506021_eng.pdf, accessed 31 August 2020)
2. mhGAP community toolkit: field test version. Geneva: World Health Organization; 2019 (https://www.who.int/publications/i/item/the-mhgap-community-toolkit-field-test-version, accessed 31 August 2020).
3. Sustainable Development Goals. SDG indicators metadata repository. In: United Nations Statistics Division [website] (https://unstats.un.org/sdgs/metadata/, accessed 31 August 2020).
4. 2018 global reference list of 100 core health indicators (plus health-related SDGs). Geneva: WHO; 2018 (https://apps.who.int/iris/bitstream/handle/10665/259951/WHO-HIS-IER-GPM-2018.1-eng.pdf, accessed 31 August 2020).
5. Global action plan on the public health response to dementia 2017–2025. Geneva: World Health Organization; 2017 (https://www.who.int/mental_health/neurology/dementia/action_plan_2017_2025/en/, accessed 31 August 2020).

Other

mhGAP intervention guide for mental, neurological and substance use disorders in non-specialized health settings. Version 2.0. Geneva: World Health Organization; 2016 (https://www.who.int/publications/i/item/mhgap-intervention-guide---version-2.0, accessed 31 August 2020).

Thirteenth General Programme of Work (GPW13) methods for impact measurement. Geneva: World Health Organization; 2020 (https://www.who.int/publications/m/item/thirteenth-general-programme-of-work-(gpw13)-methods-for-impact-measurement, accessed 31 August 2020).

43. NUMBER/PROPORTION OF PEOPLE WITH MENTAL, NEUROLOGIC AND SUBSTANCE USE (MNS) DISORDERS RECEIVING SERVICES

COMMENT

Mental disorders contribute to 7% of the global burden of diseases and have significant impacts on health and major social, human rights and economic consequences in all countries of the world. Approximately half of all mental disorders start by age 14, and suicide is the second leading cause of death in young people aged 15–29. Yet, often people with mental health conditions receive no treatment for their condition, despite the evidence that effective interventions can be delivered in any resource context.

MNS disorders refer here to the following priority conditions identified in WHO's mental health Gap Action Programme (mhGAP): psychosis, depression, bipolar disorder, epilepsy, developmental disorders, behavioural disorders, dementia, alcohol use disorder, drug use disorders, suicide/self-harm. These conditions are therefore proposed as tracer conditions.

The proportion of people with MNS disorders receiving mental health services is an indicator for service coverage and linked to SGD target 3.4 and WHO's comprehensive *Mental health action plan 2013–2030 (1)*.

The early stages of life present a particularly important opportunity to promote mental health and prevent mental disorders. Since up to 50% of mental disorders begin before the age of 14 years, data disaggregation by age and specifically for adolescents is crucial.

Likewise, mental health conditions are common in people with HIV, TB or NTDs, and have an impact on their outcomes. For example, most NTDs can lead to depression as a result of stigmatization and/or disabilities; some can also cause epilepsy (e.g. neurocysticercosis) or dementia (e.g. sleeping sickness). Monitoring mental health and well-being for these populations is therefore a necessity.

CHW TASK

Identify and provide services to people with MNS disorders/mental health conditions.

CHW DATA POINTS TO COLLECT

Number of people with MNS disorders/mental health conditions receiving services.

NUMERATOR

Number of people with MNS disorders/mental health conditions receiving services.

DENOMINATOR

Total number of people assessed for MNS disorders/mental health conditions.

DISAGGREGATION

Basic

- Gender (male, female, transgender)
- Pregnancy, postpartum
- Age (10–14, 15–19, 20+)
- Geographic area
- Type of MNS disorder: Depression, psychoses, epilepsy, child and adolescent mental and behavioural conditions, dementia, substance use conditions, suicide/self-harm
- Sub-populations with comorbid conditions (HIV, TB, NTDs)

Advanced

- Socioeconomic status (wealth quintile)
- Education level
- Age (10–14, 15–19, 20–24, 25–29, 30–34, 35–39, 40–44, 45–49, 50–54, 55–59, 60–64, 65–69, 70–74, 75–79, 80+)

MATURITY LEVEL

B/C.

FREQUENCY

At least once a year.

DIGITALIZATION

Disaggregation can be automatic, especially for age, geographic area, sex, education level and socioeconomic status if feasible.

ALIGNMENT

SDG *(2)*: The SDGs make specific reference to UHC of mental health under target 3.4 (By 2030, reduce by one third premature mortality from noncommunicable diseases through prevention and treatment and promote mental health and well-being).

The SDGs also make specific reference to the prevention and treatment of substance abuse in target 3.5. Alcohol consumption is specifically addressed in SDG indicator 3.5.2 on alcohol consumption: "Alcohol per capita consumption (aged 15 years and older) within a calendar year in litres of pure alcohol".

WHO 100 indicators: Partial; only service coverage for severe mental disorders is included *(3)*

Other:

In 2013, the World Health Assembly implemented the WHO's comprehensive *Mental health action plan 2013–2020 (1)*, which articulated pragmatic guidelines for the delivery of services, especially in low- and middle-income countries (LMICs). The action plan includes the target "service coverage for severe mental disorders will have increased by 20% [by the year 2020]" and the accompanying indicator "the proportion of persons with a severe mental disorder (psychosis, bipolar affective disorder, moderate-severe depression) who are using services". During the Seventy-second World Health Assembly (2019) the period of the action plan was extended to 2030 in order to ensure their alignment with the 2030 Agenda for Sustainable Development.

In 2017, the World Health Assembly adopted the global action plan on the public health response to dementia, outlining key actions and global targets across seven strategic areas. One of these areas aims to increase the diagnostic rate for dementia to at least 50% in at least half of WHO's Member States by 2025 *(4)*.

REFERENCES

1. Mental health action plan 2013–2020. Geneva: World Health Organization; 2013 (https://apps.who.int/iris/bitstream/handle/10665/89966/9789241506021_eng.pdf, accessed 31 August 2020)
2. Sustainable Development Goals. SDG indicators metadata repository. In: United Nations Statistics Division [website] (https://unstats.un.org/sdgs/metadata/, accessed 31 August 2020).
3. 2018 global reference list of 100 core health indicators (plus health-related SDGs). Geneva: WHO; 2018 (https://apps.who.int/iris/bitstream/handle/10665/259951/WHO-HIS-IER-GPM-2018.1-eng.pdf, accessed 31 August 2020).
4. Global action plan on the public health response to dementia 2017–2025. Geneva: World Health Organization; 2017 (https://www.who.int/mental_health/neurology/dementia/action_plan_2017_2025/en/, accessed 31 August 2020).

Other

mhGAP intervention guide for mental, neurological and substance use disorders in non-specialized health settings. Version 2.0. Geneva: World Health Organization; 2016 (https://www.who.int/publications/i/item/mhgap-intervention-guide-–-version-2.0, accessed 31 August 2020).

Thirteenth General Programme of Work (GPW13) methods for impact measurement. Geneva: World Health Organization; 2020 (https://www.who.int/publications/m/item/thirteenth-general-programme-of-work-(gpw13)-methods-for-impact-measurement, accessed 31 August 2020).

44. NUMBER OF PREGNANCY-RELATED DEATHS

COMMENT

Pregnancy-related deaths are deaths of women from any cause while pregnant, during childbirth, or within two months of delivery or end of pregnancy.

When CHWs collect information on deaths at household level, the same form can be used for all death-related indicators. Then the indicators can be extracted based on that unique form.

CHW TASK

Death notification.

Identification of a pregnancy-related death.

CHW DATA POINTS TO COLLECT

Number of new pregnancy-related deaths in the reporting period.

NUMERATOR

Number of new pregnancy-related deaths in the reporting period.

DENOMINATOR

None.

DISAGGREGATION

Basic

- Geographic area
- Place of occurrence and place of usual residence
- While pregnant, during childbirth at community, during childbirth at facility, within two months of delivery or end of pregnancy
- Age (10–14, 15–19, 20+)

Advanced

- Ethnic group
- Migratory status
- Socioeconomic status (wealth quintile)
- Main education level

MATURITY LEVEL

A.

FREQUENCY

At least once a year.

DIGITALIZATION

Interoperability with death notification services would allow better case review.

Disaggregation can be automatic, especially for age, sex, geographic area, HIV status, maternal or main caregiver's education level, ethnic group and socioeconomic status, if feasible.

ALIGNMENT

SDG: 3.1.1: Maternal mortality ratio *(1)*

WHO 100 indicators: Maternal mortality ratio *(2)*

Global Strategy for Women's, Children's and Adolescents' Health: Maternal mortality ratio *(3)*

HDC facility guidance: RMNCAH: Maternal deaths in health facility *(4)*

REFERENCES

1. Sustainable Development Goals. SDG indicators metadata repository. In: United Nations Statistics Division [website] (https://unstats.un.org/sdgs/metadata/, accessed 31 August 2020).
2. 2018 global reference list of 100 core health indicators (plus health-related SDGs). Geneva: WHO; 2018 (https://apps.who.int/iris/bitstream/handle/10665/259951/WHO-HIS-IER-GPM-2018.1-eng.pdf, accessed 31 August 2020).
3. Global Health Observatory (GHO) Data [online database]. Global Strategy for Women's, Children's and Adolescents' Health (2016–2030): Data portal. In: World Health Organization [website] (https://www.who.int/gho/publications/gswcah_portal/en/, accessed 31 August 2020).
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45. NUMBER OF STILLBIRTHS (LATE FETAL DEATHS)

COMMENT

Fetal deaths are deaths of a product of conception prior to the complete expulsion or extraction from its mother, irrespective of the duration of pregnancy; the death is indicated by the fact that after such separation the fetus does not breathe or show any other evidence of life, such as beating of the heart, pulsation of the umbilical cord, or definite movement of voluntary muscles. For statistical purposes, the following standard definitions from the 10th revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10) are generally used:

Stillbirths: Death of a fetus weighing at least 1000 g, or of at least 28 weeks' gestation or measuring at least 35 cm in length if birthweight is unknown *(1)*.

The definition recommended by WHO for international comparison ("a baby born with no signs of life at or after 28 weeks' gestation") would be easier as a definition for the CHW to get the information.

It is important to measure together stillbirths and neonatal mortality as there may be misclassification between these two indicators. Supporting supervision and implementation of a learning culture are important to improve quality of reporting. Reporting for auditing each fetal and newborn death is encouraged in that context.

Standardization at national level on the best way to recognize fetal deaths is important if there is uncertainty around gestational age or fetus weight, and should be indicated when sharing this indicator at national or global levels.

CHW TASK

Death notification.

Identification of a late fetal death.

CHW DATA POINTS TO COLLECT

Number of stillbirths: Babies born with no signs of life at or after 28 weeks' gestation.

NUMERATOR

Number of stillbirths: Babies born with no signs of life at or after 28 weeks' gestation *(2)*.

DENOMINATOR

None.

DISAGGREGATION

Basic

- Age (10–14, 15–19, 20+)
- Place of occurrence and place of usual residence
- Geographic area
- Gestational age by week

Advanced

- Before (antepartum) or after (intrapartum) the onset of labour
- Socioeconomic status
- Maternal education level
- HIV status of mother
- Number of gestations plus parity
- Ethnic group
- Migratory status

MATURITY LEVEL

B/C.

B: Longitudinal tracking is necessary to avoid double counting.

C: Disaggregation by HIV status implies interoperability between structures and records to check the mother's status and link this information with the stillbirth.

FREQUENCY

Monthly.

DIGITALIZATION

Disaggregation can be automatic, especially for age, gestational age, geographic area, HIV status, ethnic group, maternal education level, socioeconomic status, and number of gestations plus parity, if feasible.

ALIGNMENT

WHO 100 indicators: Stillbirth rate *(3)*

Global Strategy for Women's, Children's and Adolescents' Health: Stillbirth rate *(4)*

HDC facility guidance: RMNCAH: Stillbirths in health facility *(5)*

REFERENCES

1. Making every baby count: audit and review of stillbirths and neonatal deaths. Geneva: World Health Organization; 2016 (https://www.who.int/docs/default-source/mca-documents/maternal-nb/making-every-baby-count.pdf, accessed 31 August 2020).
2. Stillbirths. In: World Health Organization [website] (https://www.who.int/maternal_child_adolescent/epidemiology/stillbirth/en/, accessed 31 August 2020).
3. 2018 global reference list of 100 core health indicators (plus health-related SDGs). Geneva: WHO; 2018 (https://apps.who.int/iris/bitstream/handle/10665/259951/WHO-HIS-IER-GPM-2018.1-eng.pdf, accessed 31 August 2020).
4. Global Health Observatory (GHO) Data [online database]. Global Strategy for Women's, Children's and Adolescents' Health (2016–2030): Data portal. In: World Health Organization [website] (https://www.who.int/gho/publications/gswcah_portal/en/, accessed 31 August 2020).
5. Analysis and use of health facility data: guidance for RMNCAH programme managers. Working Document. October 2019. Geneva: World Health Organization; 2019 (https://www.who.int/healthinfo/FacilityAnalysisGuidance_RMNCAH.pdf, accessed 31 August 2020).

Other

ICD-10 Version: 2010. International Statistical Classification of Diseases and Related Health Problems 10th Revision [online database]. In: World Health Organization [website] (https://icd.who.int/browse10/2010/en, accessed 31 August 2020.

46. NUMBER OF NEONATAL DEATHS (0–27 DAYS)

COMMENT

This indicator is a subset of the number of child deaths.

It is important to measure early fetal deaths, stillbirths and neonatal mortality as there may be misclassification between these three indicators due to fear of reporting neonatal mortality. Supporting supervision and implementation of a learning culture are important to improve quality of reporting. Reporting for auditing each fetal and newborn death is encouraged in that context.

CHW TASK

Death notification.

Identification of a newborn death.

CHW DATA POINTS TO COLLECT

Number of newborn deaths (during the first 27 completed days of life).

NUMERATOR

Number of newborn deaths (during the first 27 completed days of life).

DENOMINATOR

None.

DISAGGREGATION

Basic

- Age
- Sex (male, female)
- Place of occurrence and place of usual residence
- Geographic area
- First day (< 24 hours), early (1–6 completed days of life) or not (7–27 days of life)

Advanced

- Socioeconomic status (wealth quintile)
- Maternal or main caregiver's education level
- HIV status of mother
- Ethnic group
- Migratory status

MATURITY LEVEL

B/C.

B: Longitudinal tracking is necessary to avoid double counting.

C: Disaggregation by HIV status implies interoperability between structures and records to check the mother's status and link this information with the neonatal death.

FREQUENCY

At least once a year.

DIGITALIZATION

Interoperability with death notification services would allow better case review.

Disaggregation can be automatic, especially for age, sex, geographic area, HIV status, maternal or main caregiver's education level, ethnic group and socioeconomic status, if feasible.

ALIGNMENT

SDG: 3.2.2: Neonatal mortality rate *(1)*

WHO 100 indicators: Neonatal mortality rate *(2)*

Global Strategy for Women's, Children's and Adolescents' Health: Neonatal mortality rate *(3)*

HDC facility guidance: RMNCAH: Neonatal deaths in health facility *(4)*

REFERENCES

1. Sustainable Development Goals. SDG indicators metadata repository. In: United Nations Statistics Division [website] (https://unstats.un.org/sdgs/metadata/, accessed 31 August 2020).
2. 2018 global reference list of 100 core health indicators (plus health-related SDGs). Geneva: WHO; 2018 (https://apps.who.int/iris/bitstream/handle/10665/259951/WHO-HIS-IER-GPM-2018.1-eng.pdf, accessed 31 August 2020).
3. Global Health Observatory (GHO) Data [online database]. Global Strategy for Women's, Children's and Adolescents' Health (2016–2030): Data portal. In: World Health Organization [website] (https://www.who.int/gho/publications/gswcah_portal/en/, accessed 31 August 2020).
4. Analysis and use of health facility data: guidance for RMNCAH programme managers. Working Document. October 2019. Geneva: World Health Organization; 2019 (https://www.who.int/healthinfo/FacilityAnalysisGuidance_RMNCAH.pdf, accessed 31 August 2020).

Other

Making every baby count: audit and review of stillbirths and neonatal deaths. Geneva: World Health Organization; 2016 (https://www.who.int/docs/default-source/mca-documents/maternal-nb/making-every-baby-count.pdf, accessed 31 August 2020).

47. PROPORTION OF NEWBORNS DELIVERED IN THE COMMUNITY WHO WERE PUT TO BREAST WITHIN THE FIRST HOUR OF BIRTH

COMMENT

Births should be assisted by SBAs. Regardless of existing policies, if a live birth occurs in the community, it is important to ensure that best practices are in place.

CHW TASK

Ensure newborns are put to breast within one hour of birth for community deliveries and recording it.

CHW DATA POINTS TO COLLECT

Number of newborns delivered in the community put to breast within one hour of birth in the reporting period.

NUMERATOR

Number of newborns delivered in the community put to breast within one hour of birth in the reporting period.

DENOMINATOR

Number of live births delivered in the community in the reporting period.

DISAGGREGATION

Basic

- Geographic area

Advanced

- Age of mother
- Socioeconomic status
- Maternal education
- Number of gestations plus parity

MATURITY LEVEL

B.

FREQUENCY

Monthly.

DIGITALIZATION

Disaggregation can be automatic, if the mother and newborn record data can be linked, especially for age, geographic area, maternal education, socioeconomic status and number of gestations plus parity, if feasible.

ALIGNMENT

WHO 100 indicators: Early initiation of breastfeeding *(1)*

Global Strategy for Women's, Children's and Adolescents' Health: Early initiation of breastfeeding *(2)*

HDC facility guidance: Nutrition: Newborns breastfed within one hour of birth [pending publication]

REFERENCES

1. 2018 global reference list of 100 core health indicators (plus health-related SDGs). Geneva: WHO; 2018 (https://apps.who.int/iris/bitstream/handle/10665/259951/WHO-HIS-IER-GPM-2018.1-eng.pdf, accessed 31 August 2020).
2. Global Health Observatory (GHO) Data [online database]. Global Strategy for Women's, Children's and Adolescents' Health (2016–2030): Data portal. In: World Health Organization [website] (https://www.who.int/gho/publications/gswcah_portal/en/, accessed 31 August 2020).

48. PROPORTION OF NEWBORNS DELIVERED IN THE COMMUNITY WITH DOCUMENTED BIRTHWEIGHT

COMMENT

Births should be assisted by SBAs. Regardless of existing policies, if a live birth occurs in the community, it is important to ensure that best practices are in place. Weight measurement for births at the community level requires specific material, training and supervision that is not currently available and feasible in many settings. Still, this indicator should be considered when feasible, with standardization of measurement process (including scales used), dedicated training and continuous focus on quality of measurement to ensure validity and reliability.

Birthweight should be taken and recorded within an hour after birth.

CHW TASK

Take and record newborns' weight at birth, including recording of those without a weight in the register.

CHW DATA POINTS TO COLLECT

- Number of newborns delivered in the community with documented birthweight in record or register.
- Number of live births in the community.

NUMERATOR

Number of newborns delivered in the community weighed by CHW within an hour after birth with documented birthweight in record or register.

DENOMINATOR

Number of live births delivered in the community.

DISAGGREGATION

Basic

- Geographic area
- Sex

Advanced

- None.

MATURITY LEVEL

B.

FREQUENCY

Monthly.

DIGITALIZATION

Disaggregation can be automatic for geographic area.

ALIGNMENT

HDC facility guidance: RMNCAH: Babies with documented birthweight *(1)*

REFERENCES

1. Analysis and use of health facility data: guidance for RMNCAH programme managers. Working Document. October 2019. Geneva: World Health Organization; 2019 (https://www.who.int/healthinfo/FacilityAnalysisGuidance_RMNCAH.pdf, accessed 31 August 2020).

Other

Pregnancy, childbirth, postpartum and newborn care: a guide for essential practice. 3rd edition. Geneva: World Health Organization; 2015 (https://www.ncbi.nlm.nih.gov/books/NBK326680/, accessed 31 August 2020).

49. PREVALENCE OF LOW BIRTHWEIGHT AMONG NEWBORNS DELIVERED IN THE COMMUNITY

COMMENT

Births should be assisted by SBAs. Regardless of existing policies, if a live birth occurs in the community, it is important to ensure that best practices are in place. Weight measurement at the community level requires specific material, training and supervision that is not currently available and feasible in many settings. Still, this indicator should be considered when feasible, with standardization of measurement process (including scales used), dedicated training and continuous focus on quality of measurement to ensure validity and reliability.

Birthweight should be done within an hour after birth.

CHW TASK

Take and record newborns' weight at birth.

CHW DATA POINTS TO COLLECT

- Number of newborns delivered in the community weighed by CHW within an hour after birth, with birthweight less than 2500 g.
- Number of live births weighed by CHW.

NUMERATOR

Number of neonates delivered in the community with birthweight less than 2500 g.

DENOMINATOR

Number of live births delivered in the community weighed by CHW within an hour after birth.

DISAGGREGATION

Basic

- Geographic area

Advanced

- When recording/reporting is digitized:
- Sex (male, female)
- Referral (initiated, completed)
- Birthweight (< 1000g, 1000–1499 g, 1500–1999 g, 2000–2499 g)
- Age of mother
- Gestational age (preterm status)
- Socioeconomic status
- Mother's education level

MATURITY LEVEL

B.

FREQUENCY

Monthly.

DIGITALIZATION

If the system is fully digitized, the actual birthweight can be aggregated through the system and disaggregation can be automatic, especially for mother's age, gestational age and sex, geographic area, maternal education level and socioeconomic status.

The birthweight group reports can be pulled automatically from the weight filled in by the CHW and this could also facilitate assessment of data quality.

ALIGNMENT

WHO 100 indicators: Incidence of low birth weight among newborns *(1)*

Global Nutrition Monitoring Framework indicators: Incidence of low birthweight among newborns *(2)*

HDC facility guidance: Nutrition: Low birthweight [pending publication]

REFERENCES

1. 2018 global reference list of 100 core health indicators (plus health-related SDGs). Geneva: WHO; 2018 (https://apps.who.int/iris/bitstream/handle/10665/259951/WHO-HIS-IER-GPM-2018.1-eng.pdf, accessed 31 August 2020).
2. Global Nutrition Monitoring Framework: operational guidance for tracking progress in meeting targets for 2025. Geneva: World Health Organization; 2017 (https://www.who.int/publications/i/item/9789241513609, accessed 31 August 2020).

Other

Pregnancy, childbirth, postpartum and newborn care: a guide for essential practice. 3rd edition. Geneva: World Health Organization; 2015 (https://www.ncbi.nlm.nih.gov/books/NBK326680/, accessed 31 August 2020).

50. NUMBER OF PRETERM NEWBORNS DISCHARGED FROM FACILITY THAT RECEIVED FOLLOW-UP ON KANGAROO MOTHER CARE (KMC) BY CHW

COMMENT

The delivery of Kangaroo Mother Care (KMC) in facilities is increasing; this indicator is important to measure implementation and progress towards effective coverage.

CHW TASK

KMC follow-up on preterm newborns discharged from facility.

CHW DATA POINTS TO COLLECT

Number of preterm newborns discharged from facility that received follow-up on KMC by CHW.

NUMERATOR

Number of preterm newborns discharged from facility that received follow-up on KMC by CHW.

DENOMINATOR

None.

DISAGGREGATION

Basic

- Age of mother
- Geographic area

Advanced

- Socioeconomic status
- Maternal education
- Number of gestations plus parity
- Gestational age (preterm status)

MATURITY LEVEL

C.

Longitudinal follow-up is necessary, as well as interoperability of records between structures.

FREQUENCY

Monthly.

DIGITALIZATION

If a newborn can be tracked with a unique identifier, interoperability with the facility could allow alerts to be sent automatically when a newborn goes home after birth and is in need of KMC follow-up.

Disaggregation can be automatic, especially for the mother's age, gestational age, geographic area, maternal education, socioeconomic status and number of gestations plus parity, if feasible.

ALIGNMENT

None.

REFERENCES

1. Guenther T, Moxon S, Valsangkar B, Wetzel G, Ruiz J, Kerber K, et al. Consensus-based approach to develop a measurement framework and identify a core set of indicators to track implementation and progress towards effective coverage of facility-based Kangaroo Mother Care. J Glob Health. 2017;7(2):020801. doi:10.7189/jogh.07.020801 (https://www.healthynewbornnetwork.org/hnn-content/uploads/KMC-indicators.pdf, accessed 31 August 2020).

51. PROPORTION OF PRETERM NEWBORNS DELIVERED IN THE COMMUNITY

CHW TASK

Recording of birth and assistance of births in the community; preterm birth date identification.

CHW DATA POINTS TO COLLECT

Number of newborns born at < 37 weeks' estimated gestation.

Number of live births delivered by CHW in the community.

NUMERATOR

Number of newborns born at < 37 weeks' estimated gestation.

DENOMINATOR

Number of live births delivered in the community.

DISAGGREGATION

Basic

- Geographic area
- Sex
- Gestational age (preterm status)

Advanced

- Birth weight (< 1000 g, 1000–1499 g, 1500–1999 g, 2000–2499 g)
- Number of ANC contacts
- Socioeconomic status (wealth quintile)
- Mother's education
- Number of gestations plus parity

MATURITY LEVEL

C.

Longitudinal follow-up is necessary, as well as interoperability of records between structures to establish gestational age.

FREQUENCY

Monthly.

DIGITALIZATION

Disaggregation can be automatic, especially the gestational age, geographic area, sex, ANC contacts' number, number of gestations plus parity, education level and socioeconomic status, if feasible.

The birthweight group reports can be pulled automatically from the weight filled in by the CHW.

ALIGNMENT

HDC facility guidance: RMNCAH: Preterm birth *(1)*

REFERENCES

1. Analysis and use of health facility data: guidance for RMNCAH programme managers. Working Document. October 2019. Geneva: World Health Organization; 2019 (https://www.who.int/healthinfo/FacilityAnalysisGuidance_RMNCAH.pdf, accessed 31 August 2020).

52. NUMBER/PROPORTION OF NEWBORNS AND CHILDREN REFERRED FOR DANGER SIGNS

COMMENT

This indicator aims to review how many newborns and children are referred for danger signs, and ideally whether the referral was completed.

CHW TASK

Identification and referral of newborns and children with danger signs.

CHW DATA POINTS TO COLLECT

- Number of newborns and children with danger signs non-referred/referred.
- Number of newborns and children consultations during the reporting period.

NUMERATOR

Number of newborns and children with danger signs referred.

DENOMINATOR

- Number of newborns and children with danger signs.
- Number of newborns and children consultations during the reporting period.

DISAGGREGATION

Basic

- Non-referred, referred
- Geographic area
- Age (0–27 completed days, 28 days to 11 months, 1–4 years, 5–9 years)
- Sex (male, female, intersex)

Advanced

- Referral completed
- Main caregiver's socioeconomic status
- Main caregiver's education level
- HIV status of mother and child
- Ethnic group
- Migratory status

MATURITY LEVEL

C.

Longitudinal follow-up and data exchange with facility are critical to review whether referral was completed.

FREQUENCY

Monthly.

DIGITALIZATION

Interoperability with facility data is critical to know when referral has been completed (arrived in the facility).

Disaggregation can be automatic, especially for age, sex, geographic area, HIV status, main caregiver's education level and socioeconomic status, ethnic group, if feasible.

ALIGNMENT

None.

REFERENCES

None.

53. PROPORTION OF NEWBORNS DELIVERED IN THE COMMUNITY INITIATED ON SKIN-TO-SKIN CONTACT IMMEDIATELY AFTER BIRTH

COMMENT

Births should be assisted by SBAs. Regardless of existing policies, if a live birth occurs in the community, it is important to ensure that best practices are in place.

CHW TASK

Initiation of skin-to-skin contact immediately after birth.

CHW DATA POINTS TO COLLECT

- Number of newborns initiated on skin-to-skin contact immediately after birth.
- Number of live births delivered in the community.

NUMERATOR

Number of newborns initiated on skin-to-skin contact immediately after birth (newborns should be counted once).

DENOMINATOR

Number of live births delivered in the community.

DISAGGREGATION

Basic

- Geographic area
- Birth weight (< 1000 g, 1000–1499 g, 1500–1999 g, 2000–2499 g, > 2500 g)
- Sex
- Gestational age (preterm status)

Advanced

- Socioeconomic status (wealth quintile)
- Maternal education

MATURITY LEVEL

A.

FREQUENCY

Monthly.

DIGITALIZATION

Disaggregation can be automatic, especially for gestational age, geographic area, maternal education level and socioeconomic status. The birthweight group reports can be pulled automatically from the weight filled in by the CHW.

ALIGNMENT

None.

REFERENCES

None.

54. NEWBORNS DELIVERED IN THE COMMUNITY WHOSE CORD WAS CUT WITH CLEAN INSTRUMENT

COMMENT

Births should be assisted by SBAs.

Regardless of existing policies, if a live birth occurs in the community, it is important to ensure that best practices are in place.

CHW TASK

Cord cutting with clean instrument and its promotion.

CHW DATA POINTS TO COLLECT

- Number of newborns born in the community who had their umbilical cord cut with a new blade or boiled instrument.
- Number of live births in community.

NUMERATOR

Number of newborns born in the community who had their umbilical cord cut with a new blade or boiled instrument.

DENOMINATOR

Number of live births delivered in the community.

DISAGGREGATION

Basic

- Delivery by lay person/CHW
- Geographic area
- Sex
- Referral

Advanced

- Socioeconomic status (wealth quintile)
- Mother's education level

MATURITY LEVEL

A.

FREQUENCY

Monthly.

DIGITALIZATION

Disaggregation can be automatic, especially for geographic area, sex, maternal education level and socioeconomic status.

ALIGNMENT

None.

REFERENCES

None.

55. NUMBER OF INFANT DEATHS (0 TO LESS THAN 1 YEAR OLD)

COMMENT

Feasibility of reporting infant deaths will depend on the catchment area (size, access, etc.). One unique form can be used to report deaths, specifying the age. Then indicators can be built, based on this form.

CHW TASK

Death notification by age.

CHW DATA POINTS TO COLLECT

Number of new infant deaths in the reporting period.

NUMERATOR

Number of new infant deaths (0 to less than 1 year old) in the reporting period.

DENOMINATOR

None.

DISAGGREGATION

Basic

- Geographic area
- Place of occurrence and place of usual residence
- Sex (male, female)
- Age (it is recommended to record the precise age counted in months before 1 year of age)

Advanced

- Maternal or main caregiver's wealth
- HIV status of mother and child
- Ethnic group
- Migratory status

MATURITY LEVEL

A.

FREQUENCY

At least once a year.

DIGITALIZATION

Interoperability with death notification services would allow better case review.

Disaggregation can be automatic, especially for age, sex, geographic area, HIV status, maternal or main caregiver's education level, ethnic group, socioeconomic status, if feasible.

ALIGNMENT

SDG: 3.2.1: Under-5 mortality rate *(1)*

WHO 100 indicators: Under-five mortality rate *(2)*

Global Strategy for Women's, Children's and Adolescents' Health: Under-5 mortality rate *(3)*

REFERENCES

1. Sustainable Development Goals. SDG indicators metadata repository. In: United Nations Statistics Division [website] (https://unstats.un.org/sdgs/metadata/, accessed 31 August 2020).
2. 2018 global reference list of 100 core health indicators (plus health-related SDGs). Geneva: WHO; 2018 (https://apps.who.int/iris/bitstream/handle/10665/259951/WHO-HIS-IER-GPM-2018.1-eng.pdf, accessed 31 August 2020).
3. Global Health Observatory (GHO) Data [online database]. Global Strategy for Women's, Children's and Adolescents' Health (2016–2030): Data portal. In: World Health Organization [website] (https://www.who.int/gho/publications/gswcah_portal/en/, accessed 31 August 2020).

56. NUMBER OF CHILD DEATHS (1 TO LESS THAN 5 YEARS OLD)

COMMENT

Feasibility of reporting child deaths will depend on the catchment area (size, access, etc.). One unique form can be used to report deaths, specifying the age. Then indicators can be built, based on this form.

CHW TASK

Death notification by age.

CHW DATA POINTS TO COLLECT

Number of new child deaths (1 to less than 5 years old) in the reporting period.

NUMERATOR

Number of new child deaths (1 to less than 5 years old) in the reporting period.

DENOMINATOR

None.

DISAGGREGATION

Basic

- Geographic area
- Place of occurrence and place of usual residence
- Sex (male, female)
- Age (it is recommended to record the precise age counted in years)

Advanced

- Maternal or main caregiver's wealth
- HIV status of mother and child
- Ethnic group
- Migratory status

MATURITY LEVEL

A.

FREQUENCY

At least once a year.

DIGITALIZATION

Interoperability with death notification services would allow better case review.

Disaggregation can be automatic, especially for age, sex, geographic area, HIV status, maternal or main caregiver's education level, ethnic group and socioeconomic status, if feasible.

ALIGNMENT

SDG: 3.2.1: Under-5 mortality rate (1)

WHO 100 indicators: Under-5 mortality rate (2)

Global Strategy for Women's, Children's and Adolescents' Health: Under-5 mortality rate (3)

HDC facility guidance: RMNCAH: Child deaths in health facility (4)

REFERENCES

1. Sustainable Development Goals. SDG indicators metadata repository. In: United Nations Statistics Division [website] (https://unstats.un.org/sdgs/metadata/, accessed 31 August 2020).
2. 2018 global reference list of 100 core health indicators (plus health-related SDGs). Geneva: WHO; 2018 (https://apps.who.int/iris/bitstream/handle/10665/259951/WHO-HIS-IER-GPM-2018.1-eng.pdf, accessed 31 August 2020).
3. Global Health Observatory (GHO) Data [online database]. Global Strategy for Women's, Children's and Adolescents' Health (2016–2030): Data portal. In: World Health Organization [website] (https://www.who.int/gho/publications/gswcah_portal/en/, accessed 31 August 2020).
4. Analysis and use of health facility data: guidance for RMNCAH programme managers. Working Document. October 2019. Geneva: World Health Organization; 2019 (https://www.who.int/healthinfo/FacilityAnalysisGuidance_RMNCAH.pdf, accessed 31 August 2020).

57. NUMBER OF CHILD DEATHS (5 TO LESS THAN 10 YEARS OLD)

COMMENT

Feasibility of reporting child deaths will depend on the catchment area (size, access, etc.).

One unique form can be used to report deaths, specifying the age.

Then indicators can be built, based on this form.

CHW TASK

Death notification by age.

CHW DATA POINTS TO COLLECT

Number of new child deaths (5 to less than 10 years old) in the reporting period.

NUMERATOR

Number of new child deaths (5 to less than 10 years old) in the reporting period.

DENOMINATOR

None.

DISAGGREGATION

Basic

- Geographic area
- Place of occurrence and place of usual residence
- Sex (male, female)
- Age (it is recommended to record the precise age counted in years)

Advanced

- Maternal or main caregiver's wealth
- HIV status of mother and child
- Ethnic group
- Migratory status

MATURITY LEVEL

A.

FREQUENCY

At least once a year.

DIGITALIZATION

Interoperability with death notification services would allow better case review.

Disaggregation can be automatic, especially for age, sex, geographic area, HIV status, maternal or main caregiver's education level, ethnic group and socioeconomic status, if feasible.

ALIGNMENT

HDC facility guidance: RMNCAH: Child deaths in health facility *(1)*

REFERENCES

1. Analysis and use of health facility data: guidance for RMNCAH programme managers. Working Document. October 2019. Geneva: World Health Organization; 2019 (https://www.who.int/healthinfo/FacilityAnalysisGuidance_RMNCAH.pdf, accessed 31 August 2020).

58. PROPORTION OF CONSULTATIONS FOR INFANTS UNDER 6 MONTHS PROVIDING COUNSELLING ON APPROPRIATE INFANT AND YOUNG CHILD FEEDING

COMMENT

It is critical that mothers of infants under 6 months receive counselling at every consultation.

CHW TASK

Provide counselling on appropriate feeding – that is, required support to practise exclusive breastfeeding and guidance on feeding in cases where mothers experience breastfeeding difficulties/challenges for mothers of children aged < 6 months.

CHW DATA POINTS TO COLLECT

Number of consultations with a CHW for an infant 0–5 months providing any counselling on appropriate infant and young child feeding in the reporting period.

Total number of consultations with a CHW (including postnatal visits or other consultations) for an infant 0–5 months in the reporting period.

NUMERATOR

Number of consultations with a CHW for an infant 0–5 months providing any counselling on appropriate infant and young child feeding in the reporting period.

DENOMINATOR

Total number of consultations with a CHW (including postnatal visits or other consultations) for an infant 0–5 months old in the reporting period.

DISAGGREGATION

Basic

- Geographic area

Advanced

- None

MATURITY LEVEL

A.

FREQUENCY

Monthly.

DIGITALIZATION

Content of counselling can be a preset menu and calculation can be automated to assess an additional indicator about timely and appropriate counselling.

ALIGNMENT

Global Nutrition Monitoring Framework (indicators are being revised and should include one on counselling) *(1)*

REFERENCES

1. Global Nutrition Monitoring Framework: operational guidance for tracking progress in meeting targets for 2025. Geneva: World Health Organization; 2017 (https://www.who.int/publications/i/item/9789241513609, accessed 31 August 2020).

59. PROPORTION OF CONSULTATIONS FOR CHILDREN 6–23 MONTHS PROVIDING COUNSELLING ON APPROPRIATE COMPLEMENTARY FEEDING

COMMENT

It is critical that caregivers of infants 6–23 months receive counselling at every consultation.

CHW TASK

Provide counselling for children in this age group focused on **what** (diverse diets – inclusion of animal source foods, vegetables and fruits, avoidance of unhealthy foods, and continued breastfeeding), **when** (timely introduction of complementary foods) and **how** to feed (age-appropriate meal frequency, amount and consistency, with safe and responsive feeding) the child.

CHW DATA POINTS TO COLLECT

- Number of consultations with a CHW for children 6–23 months providing any counselling on appropriate complementary feeding in the reporting period.
- Total number of consultations with a CHW for children 6–23 months in the reporting period.

NUMERATOR

Number of consultations with a CHW for children 6–23 months providing any counselling on appropriate complementary feeding in the reporting period.

DENOMINATOR

Total number of consultations with a CHW for children 6–23 months in the reporting period.

DISAGGREGATION

Basic

- Geographic area

Advanced

- None

MATURITY LEVEL

A.

FREQUENCY

Monthly.

DIGITALIZATION

Content of counselling can be a preset menu and calculation can be automated to assess an additional indicator about timely and appropriate counselling.

If a woman can be tracked with a unique identifier and there is interoperability with facility data, another additional indicator aligned with the WHO breastfeeding guidelines can be assessed: "Proportion of women with a child 24–35 months of age who received at least six counselling contacts".

ALIGNMENT

Global Nutrition Monitoring Framework (indicators are being revised and should include one on counselling) *(1)*

REFERENCES

1. Global Nutrition Monitoring Framework: operational guidance for tracking progress in meeting targets for 2025. Geneva: World Health Organization; 2017 (https://www.who.int/publications/i/item/9789241513609, accessed 31 August 2020).

60. PROPORTION OF PEOPLE RECEIVING PREVENTIVE CHEMOTHERAPY FOR DEWORMING

COMMENT

Preventive chemotherapy is recommended for all children 1–14 years of age, non-pregnant adolescent girls and women of reproductive age.

This indicator should be aligned with national policy guidelines.

Preventive chemotherapy (PC) consists of wide-scale delivery of safe, quality-assured medicines, either alone or in combination, at regular intervals to entire population groups.

This coverage includes different groups targeted for PC for the following:

- Lymphatic filariasis, onchocerciasis and trachoma: Entire community population
- Soil-transmitted helminths : Children 1–14 years and women of childbearing age
- Schistosomiasis: Children 5–14 years and adults at high risk
- Taeniasis: Children 5–14 years and adults.

The term "deworming" is mainly associated with treatment of children. Eligible groups for treatment also depend on medicines (PC type) distributed and include mass drug administration (MDA) intervention versus targeted treatment (T) intervention:

- MDA1, MDA3 and T2: 5 years and above
- MDA2: 2 years and above
- T1: 5–14 years
- T3: 1–14 years.

CHW TASK

PC for deworming. CHWs are part of the team in charge of the PC campaigns (mobilization, distribution, evaluation).

CHW DATA POINTS TO COLLECT

Number of people receiving a dose of PC for deworming according to national policy.

NUMERATOR

Number of people receiving a dose of PC for deworming according to national policy.

DENOMINATOR

- Number of children 1–9 years of age.
- Number of non-pregnant adolescent girls (10–14, 15–19) and women of reproductive age.
- Number of people targeted for PC for deworming according to national policy.

DISAGGREGATION

Basic

- Drug (albendazole; mebendazole)
- Geographic area
- Age (1–4, 5–9, 10–14, 15–17, 18–19 should be considered for adolescents)
- Sex

Advanced

- Socioeconomic status
- Education level

MATURITY LEVEL

B.

Longitudinal follow-up is necessary to avoid double counting.

FREQUENCY

Monthly.

DIGITALIZATION

Alerts can be set every 6 to 12 months to indicate to CHW who may need PC for deworming.

Disaggregation can be automatic, especially for age, geographic area, sex, education level and socioeconomic status.

ALIGNMENT

None.

REFERENCES

1. e-Library of Evidence for Nutrition Actions (eLENA): Deworming. In: World Health Organization [website] (https://www.who.int/elena/titles/full_recommendations/deworming/en/, accessed 31 August 2020).

61. PERCENTAGE OF CHILDREN 6–59 MONTHS OF AGE WHO RECEIVED AN AGE-APPROPRIATE DOSE OF VITAMIN A THROUGH CHW CONTACTS (ROUTINE CONTACTS AS WELL AS CONTACTS VIA EVENTS) IN EACH SEMESTER

COMMENT

Report separately for each: (a) through routine contacts by CHW and (b) through events in the community; and (c) in semester 1 (January – June) and (d) semester 2 (July – December).

Administration of vitamin A is recommended for all children 6–59 months of age in some settings, according to WHO.

For dose according to age, see WHO guidance on vitamin A supplementation *(1)*.

CHW TASK

Provision of vitamin A supplements to children 6–59 months approximately every 6 months. There is a risk of double counting children dosed more than once in any semester. In addition to community distribution having different opportunities to give more than one dose in a semester (e.g. a child can have more than one routine community contact and also a community event contact in the same semester), children can also receive doses in health facilities (via routine contacts as well as events). From an implementation point of view, each child should only receive one dose in each semester. The risk of providing and counting more than one dose in any semester for any child can be reduced by encouraging the use of child health cards to monitor the child's supplementation status prior to provision of any dose (i.e. if the child already received a dose in the semester via another means, it should have been recorded in the health card and on subsequent contacts in the same semester, a second dose should not be given). Also, by reporting on events separately from routine (and not combining the routine and event figures) the risk of double counting for a coverage estimate may also be minimized.

CHW DATA POINTS TO COLLECT

- Number of children 6–59 months who received an age-appropriate dose of vitamin A via routine contacts with CHW in semester 1.
- Number of children 6–59 months who received an age-appropriate dose of vitamin A via routine contacts with CHW in semester 2.
- Number of children 6–59 months who received an age-appropriate dose of vitamin A by CHW via event in semester 1.
- Number of children 6–59 months who received an age-appropriate dose of vitamin A by CHW via event in semester 2.

NUMERATOR

Report separately for each: (a) through routine contacts with CHW and (b) by CHW via events; and (c) in semester 1 (January – June) and (d) semester 2 (July – December).

- Number of children 6–59 months who received an age-appropriate dose of vitamin A via routine contacts with CHW in semester 1.
- Number of children 6–59 months who received an age-appropriate dose of vitamin A via routine contacts with CHW in semester 2.
- Number of children 6–59 months who received an age-appropriate dose of vitamin A by CHW via event in semester 1.
- Number of children 6–59 months who received an age-appropriate dose of vitamin A by CHW via event in semester 2.

DENOMINATOR

- Total population of children aged 6–59-months with at least one community contact in semester 1.
- Total population of children aged 6–59-months with at least one community contact in semester 2.
- Total population of children aged 6–59-months attending events with vitamin A supplementation distributed via CHW in semester 1.
- Total population of children aged 6–59-months attending events with vitamin A supplementation distributed via CHW in semester 2.

Number of children aged 6–59 months (note that denominators may be different depending on the type of distribution; for example, some events like polio National Immunization Days generally have an inflated denominator when compared to the denominator used for distribution via routine contacts with CHW). Also, in cases where the child already received vitamin A supplementation in the semester at a facility, they should not receive another dose and thus should also not be counted in the denominator as having had a community contact.

DISAGGREGATION

Basic

- Disaggregation is not recommended for events, but may be considered for routine contacts:
- Doses (100 000 International Units [IU]; 200 000 IU)
- Age (6–11 months and 12–59 months)
- Geographic area

Advanced

- When recording/reporting is digitized:
- Socioeconomic status (wealth quintile)
- Main caregiver's education level
- Smaller age groups (6–11 months, 12–23 months, 24–35 months, 36–47 months, 48–59 months
- HIV status

MATURITY LEVEL

B.

Countries should report separately for each semester (January – June and July – December) and also for distribution through routine health system contacts separately from distribution through events, to avoid double counting. In addition to community distribution having different opportunities to give more than one dose in a semester (e.g. a child can have more than one routine community contact and also a community event contact in the same semester), children can also receive doses in health facilities (via routine contacts as well as events). From an implementation point of view, each child should only receive one dose in each semester. The risk of providing and counting more than one dose in any semester for any child can be reduced by encouraging the use of child health cards to monitor the child's supplementation status prior to provision of any dose (i.e. if the child already received a dose in the semester via another means, it should have been recorded in the health card and on subsequent contacts in the same semester, a second dose should not be given). Also, by reporting on events separately from routine (and not combining the routine and event figures) the risk of double counting for a coverage estimate may also be minimized.

FREQUENCY

Monthly.

DIGITALIZATION

Alerts can be set every 4–6 months to indicate to CHW who may need vitamin A supplementation. If the child has a unique ID the alert can also notify the CHW if the child already received a dose that semester through another means (e.g. health facility).

Disaggregation can be automatic, especially for age, geographic area, HIV status, main caregiver's education level and socioeconomic status.

ALIGNMENT

HDC facility guidance: RMNCAH: Vitamin A coverage *(2)*

Global Alliance for Vitamin A (GAVA) Monitoring of vitamin A supplementation: a guide for national programme managers *(3)*

REFERENCES

1. e-Library of Evidence for Nutrition Actions (eLENA): Vitamin A supplementation in infants and children 6–59 months of age. Guidance summary. In: World Health Organization [website] (https://www.who.int/elena/titles/guidance_summaries/vitamina_children/en/, accessed 31 August 2020).
2. Analysis and use of health facility data: guidance for RMNCAH programme managers. Working Document. October 2019. Geneva: World Health Organization; 2019 (https://www.who.int/healthinfo/FacilityAnalysisGuidance_RMNCAH.pdf, accessed 31 August 2020).
3. Global Alliance for Vitamin A (GAVA). Monitoring of vitamin A supplementation: a guide for national programme managers. Ottawa: Micronutrient Initiative; 2017 (http://www.gava.org/content/user_files/2017/08/GAVA-national-vas-monitoring-guide-2.pdf, accessed 31 August 2020)

62. NUMBER/PROPORTION OF CHILDREN AGED 6–59 MONTHS ASSESSED FOR WASTING IN THE REPORTING PERIOD

COMMENT

This indicator is recommended to assess coverage of screening programmes for wasting and as various forms of assessment are allowed (e.g. mid-upper-arm circumference [MUAC] and weight-for-height z-score [WHZ]), which may result in counting more children as wasted than if only one index had been used; it is not recommended to report in prevalence estimates based on these data. Further, it is not recommended to report in prevalence estimates for indicators of malnutrition (e.g. wasting) through administrative systems; but in cases where a country wishes to do so, the indicator definition and denominator need to be "among children screened", and not among the entire population. Care should also be taken to report on availability of data across different age and sex groups.

CHW TASK

Screen children for wasting: based on MUAC (< 12.5 cm) or WHZ (< –2 z-score) or bilateral pitting oedema as per WHO standards and refer those in need to appropriate programme.

CHW DATA POINTS TO COLLECT

Number of children aged 6–59 months assessed using MUAC or WHZ or bilateral pitting oedema.

NUMERATOR

Number of children aged 6–59 months assessed using MUAC or WHZ or bilateral pitting oedema.

DENOMINATOR

Number of children aged 6–59 months in the community.

DISAGGREGATION

Basic

- Geographic area
- Age
- Referral
- Uptake of referral

Advanced

- None

MATURITY LEVEL

B.

Longitudinal follow-up is necessary to avoid double counting.

FREQUENCY

Monthly.

DIGITALIZATION

None.

ALIGNMENT

UNICEF Nutridash report: Number of admissions to severe acute malnutrition programmes *(1)*

REFERENCES

1. NutriDash Interactive Report 2018. New York: UNICEF; 2019.

63. PROPORTION OF CHILDREN 6–59 MONTHS WITH MID-UPPER-ARM CIRCUMFERENCE (MUAC) < 115 MM (SEVERE ACUTE MALNUTRITION)

COMMENT

The WHO UNICEF joint statement on child growth standards and the identification of severe acute malnutrition (SAM) in infants and children indicates that if the prevalence of SAM using MUAC < 115 mm or using weight-for-height < –3 standard deviations (SD) was very similar, the cases identified were not the same.

If the MUAC is clearly more feasible in many settings, it should not be considered to be a replacement for weight-for-height measurement, and ideally both should be done.

Some experts do not recommend reporting in prevalence estimates for indicators of malnutrition (e.g. wasting) through administrative systems; however, in cases where a country wishes to do so, the indicator definition and denominator need to be "among children screened", and not among the entire population. Care should also be taken to report on availability of data across different age and sex groups.

CHW TASK

Measure and record MUAC.

CHW DATA POINTS TO COLLECT

- Number of children 6–59 months with MUAC < 115 mm (SAM).
- Number of children 6–59 months screened.

NUMERATOR

Number of children 6–59 months with MUAC < 115 mm (SAM).

DENOMINATOR

Number of children 6–59 months screened.

DISAGGREGATION

Basic

- Geographic area
- Age (range if group)
- Sex
- Referral
- Uptake of referral

Advanced

- Socioeconomic status
- Main caregiver's education level

MATURITY LEVEL

B.

Longitudinal follow-up is necessary to avoid double counting.

FREQUENCY

Monthly.

DIGITALIZATION

Disaggregation can be automatic, especially for age, geographic area, sex, main caregiver's education level and socioeconomic status.

ALIGNMENT

None.

REFERENCES

1. WHO child growth standards and the identification of severe acute malnutrition in infants and children. A joint statement by the World Health Organization and the United Nations Children's Fund. Geneva and New York: WHO and UNICEF; 2009 (https://apps.who.int/iris/bitstream/handle/10665/44129/9789241598163_eng.pdf, accessed 31 August 2020).

64. NUMBER/PROPORTION OF CHILDREN UNDER 5 YEARS WHO HAD THEIR WEIGHT ASSESSED

COMMENT

It is not recommended to report in prevalence estimates for indicators of malnutrition (e.g. wasting) through administrative systems; in cases where a country wishes to do so, the indicator definition and denominator need to be "among children assessed", and not among the entire population. Care should also be taken to report on availability of data across different age and sex groups.

CHW TASK

Measure child's weight and plot it on their child health home-based record growth chart; provide counselling or refer for counselling if weight gain is problematic.

Number of children consulted by a CHW.

CHW DATA POINTS TO COLLECT

Number of children visited by a CHW whose weight was assessed.

NUMERATOR

Number of children visited by a CHW whose weight was assessed.

DENOMINATOR

Number of children consulted by a CHW worker.

DISAGGREGATION

Basic

- Geographic area
- Age

Advanced

- None

MATURITY LEVEL

B.

Longitudinal follow-up is necessary to avoid double counting.

FREQUENCY

Monthly.

DIGITALIZATION

None.

ALIGNMENT

None.

REFERENCES

None.

65. NUMBER/PROPORTION OF CHILDREN UNDER 5 YEARS WHO ARE UNDERWEIGHT

COMMENT

It is not recommended to report in prevalence estimates for indicators of malnutrition (e.g. wasting) through administrative systems; in cases where a country wishes to do so, the indicator definition and denominator need to be "among children assessed", and not among the entire population. Care should also be taken to report on availability of data across different age and sex groups.

CHW TASK

Measure a child's weight and plot it on their child health home-based record growth chart; provide counselling or refer for counselling if weight gain is problematic.

Number of children consulted by a CHW.

CHW DATA POINTS TO COLLECT

Number of children visited by a CHW and underweight (weight-for-age < –2 SD from the median of the WHO Child Growth Standards).

NUMERATOR

Number of children visited by a CHW and underweight (weight-for-age < –2 SD from the median of the WHO Child Growth Standards).

DENOMINATOR

Number of children visited by a CHW.

DISAGGREGATION

Basic

- Geographic area
- Age (0–11 months, 1–4 years)

Advanced

- Sex (male, female, intersex)

MATURITY LEVEL

B.

Longitudinal follow-up is necessary to avoid double counting.

FREQUENCY

Monthly.

DIGITALIZATION

None.

ALIGNMENT

None.

REFERENCES

None.

66. PROPORTION OF WASTING AMONG CHILDREN AGED 6–59 MONTHS

COMMENT

Height and weight measurement at the community level requires specific material, training and supervision that is not currently available and feasible in many settings.

Still, this indicator can be considered especially in settings where wasting prevalence is high, there is confidence in the accuracy of weight and height measurement, and sufficient coverage and understanding of the child population measured for the results to be interpreted appropriately.

Some experts do not recommend reporting on prevalence estimates for indicators of malnutrition (e.g. wasting) through administrative systems; however, in cases where a country wishes to do so, the indicator definition and denominator need to be "among children assessed", and not among the entire population. Care should also be taken to report on availability of data across different age and sex groups.

CHW TASK

Screen children for wasting based on MUAC (< 12.5 cm) or WHZ (< –2 z-score) or bilateral pitting oedema as per WHO standards, and refer those in need to appropriate programme.

CHW DATA POINTS TO COLLECT

- Number of children aged 6–59 months assessed using MUAC or WHZ or bilateral pitting oedema.
- Number of children aged 6–59 months that were measured.

NUMERATOR

Number of children aged 6–59 months with weight for height < –2 SD from the median of the WHO Child Growth Standards, or MUAC (< 12.5 cm) or bilateral pitting oedema.

DENOMINATOR

Number of children 6–59 months that were measured.

DISAGGREGATION

Basic

- Geographic area
- Age
- Sex (male, female)
- Referral
- Uptake of referral

Advanced

- Socioeconomic status (wealth quintile)
- Main caregiver's education level
- Severity: Moderate (WHZ between < –2 and > –3 SD); severe (WHZ below –3 SD)

MATURITY LEVEL

B.

Longitudinal follow-up is necessary.

FREQUENCY

Monthly.

DIGITALIZATION

SD from the median could be automatically calculated with feedback on results and severity.

Disaggregation can be automatic, especially for age, geographic area, sex, main caregiver's education level and socioeconomic status.

ALIGNMENT

SDG: 2.2.2: Prevalence of malnutrition (weight for height > +2 or < –2 SD from the median of the WHO Child Growth Standards) among children under 5 years of age, by type (wasting and overweight) *(1)*

WHO 100 indicators: Children under 5 years who are wasted *(2)*

Global Nutrition Monitoring Framework indicators: Children under 5 years who are wasted *(3)*

REFERENCES

1. Sustainable Development Goals. SDG indicators metadata repository. In: United Nations Statistics Division [website] (https://unstats.un.org/sdgs/metadata/, accessed 31 August 2020).
2. 2018 global reference list of 100 core health indicators (plus health-related SDGs). Geneva: WHO; 2018 (https://apps.who.int/iris/bitstream/handle/10665/259951/WHO-HIS-IER-GPM-2018.1-eng.pdf, accessed 31 August 2020).
3. Global Nutrition Monitoring Framework: operational guidance for tracking progress in meeting targets for 2025. Geneva: World Health Organization; 2017 (https://www.who.int/publications/i/item/9789241513609, accessed 31 August 2020).

67. NUMBER/PROPORTION OF CHILDREN UNDER 5 YEARS WHO HAD THEIR HEIGHT/LENGTH MEASURED

COMMENT

It is not recommended to report in prevalence estimates for indicators of malnutrition (e.g. stunting) through administrative systems; in cases where a country wishes to do so, the indicator definition and denominator need to be "among children assessed", and not among the entire population. Care should also be taken to report on availability of data across different age and sex groups.

CHW TASK

Measure child's height/length and plot it on their child health book growth chart; provide counselling or refer for counselling if linear growth is problematic.

CHW DATA POINTS TO COLLECT

Number of children visited by a CHW whose height/length was measured.

NUMERATOR

Number of children visited by a CHW whose height/length was measured.

DENOMINATOR

Number of children consulted by a CHW.

DISAGGREGATION

Basic

- Geographic area
- Age

Advanced

- None

MATURITY LEVEL

B.

Longitudinal follow-up is necessary to avoid double counting.

FREQUENCY

Monthly.

DIGITALIZATION

None.

ALIGNMENT

None.

REFERENCES

None.

68. PROPORTION OF OVERWEIGHT AMONG CHILDREN UNDER 5 YEARS OF AGE

COMMENT

Height and weight measurement at the community level requires specific material, training and supervision that is not currently available and feasible in many settings.

Still, this indicator can be considered especially in settings where overweight prevalence is a concern, there is confidence in the accuracy of weight and height measurement, and sufficient coverage and understanding of the child population measured for the results to be interpreted appropriately.

Some experts do not recommend reporting on prevalence estimates for indicators of malnutrition (e.g. wasting) through administrative systems; but in cases where a country wishes to do so, the indicator definition and denominator need to be "among children assessed", and not among the entire population. Care should also be taken to report on availability of data across different age and sex groups.

CHW TASK

Measurement of length/height and weight.

CHW DATA POINTS TO COLLECT

- Weight and length/height of children aged 0–5 years.
- Number of children aged 0–5 years that were measured.

NUMERATOR

Number of children aged 0–5 years with weight for height > +2 SD from the median of the WHO Child Growth Standards.

DENOMINATOR

Number of children aged 0–5 years that were measured.

DISAGGREGATION

Basic

- Geographic area
- Age
- Sex (male, female)
- Referral
- Uptake of referral

Advanced

- Socioeconomic status (wealth quintile)
- Main caregiver's education level
- SSeverity: Moderate (WHZ between +2 and +3 SD); severe (WHZ > +3 SD)

MATURITY LEVEL

B.

Longitudinal follow-up is necessary.

FREQUENCY

Monthly if reporting based on consultations. Less frequently (at least once a year) if reported by household assessment.

DIGITALIZATION

SD from the median could be automatically calculated with feedback on results and severity.

Disaggregation can be automatic, especially for age, geographic area, sex, main caregiver's education level and socioeconomic status.

ALIGNMENT

SDG: 2.2.2: Prevalence of malnutrition (weight for height > +2 or < –2 SD from the median of the WHO Child Growth Standards) among children under 5 years of age, by type (wasting and overweight) *(1)*

WHO 100 indicators: Children aged under 5 years who are overweight *(2)*

Global Nutrition Monitoring Framework indicators: Children under 5 years who are wasted *(3)*

REFERENCES

1. Sustainable Development Goals. SDG indicators metadata repository. In: United Nations Statistics Division [website] (https://unstats.un.org/sdgs/metadata/, accessed 31 August 2020).
2. 2018 global reference list of 100 core health indicators (plus health-related SDGs). Geneva: WHO; 2018 (https://apps.who.int/iris/bitstream/handle/10665/259951/WHO-HIS-IER-GPM-2018.1-eng.pdf, accessed 31 August 2020).
3. Global Nutrition Monitoring Framework: operational guidance for tracking progress in meeting targets for 2025. Geneva: World Health Organization; 2017 (https://www.who.int/publications/i/item/9789241513609, accessed 31 August 2020).

69. PROPORTION OF OVERWEIGHT AND OBESITY IN SCHOOL-AGE CHILDREN AND ADOLESCENTS 5–19 YEARS

COMMENT

Height and weight measurement at the community level requires specific material, training and supervision that is not currently available and feasible in many settings.

Still, this indicator can be considered when feasible considering the growing importance of noncommunicable diseases (NCDs), especially in settings where overweight prevalence is a concern, there is confidence in the accuracy of weight and height measurement, and sufficient coverage and understanding of the child population measured for the results to be interpreted appropriately.

It is critical to disaggregate at least by age groups 5–9, 10–14 and 15–19.

CHW TASK

Measurement of height and weight and age (by collecting and reporting date of birth and day of measurement).

CHW DATA POINTS TO COLLECT

- Age, sex, weight and height of children and adolescents (5–19 years).
- Number of children and adolescents (5–19 years) who were measured.

NUMERATOR

Number of children and adolescents (5–19 years) who are overweight (body mass index [BMI]-for-age > +1 SD) and obese (BMI-for-age > +2 SD).

DENOMINATOR

Number of children and adolescents (5–19 years) who were measured.

DISAGGREGATION

Basic

- Geographic area
- Age (age groups 5–9, 10–14, 15–17, 18–19)
- Sex (male, female)

Advanced

- Socioeconomic status (wealth quintile)
- Education level
- Main caregiver's education level
- Severity (overweight, obese)

MATURITY LEVEL

B.

Longitudinal follow-up is necessary.

FREQUENCY

Monthly if reporting based on consultations. Less frequently (at least once a year) if reported by household assessment.

DIGITALIZATION

BMI-for-age and SD from the median for BMI-for-age could be automatically calculated with feedback on results and severity.

Disaggregation can be automatic, especially for age, geographic area, sex, main caregiver's education level and socioeconomic status.

ALIGNMENT

WHO 100 indicators: Overweight and obesity in adults (Also: school-age children and adolescents) *(1)*

Global Nutrition Monitoring Framework indicators: Proportion of overweight in school-age children and adolescents (5–19 years) *(2)*

WHO NCD Global Monitoring Framework: Prevalence of overweight and obesity in adolescents *(3)*

REFERENCES

1. 2018 global reference list of 100 core health indicators (plus health-related SDGs). Geneva: WHO; 2018 (https://apps.who.int/iris/bitstream/handle/10665/259951/WHO-HIS-IER-GPM-2018.1-eng.pdf, accessed 31 August 2020).
2. Global Nutrition Monitoring Framework: operational guidance for tracking progress in meeting targets for 2025. Geneva: World Health Organization; 2017 (https://www.who.int/publications/i/item/9789241513609, accessed 31 August 2020).
3. NCD Global Monitoring Framework. In: World Health Organization [website] (https://www.who.int/nmh/global_monitoring_framework/en/, accessed 31 August 2020).

70. NUMBER/PROPORTION OF CHILDREN WHO RECEIVED TREATMENT FOR DIARRHOEA

COMMENT

Diarrhoea is the passage of three or more loose or liquid stools per day, or more frequently than is normal for the individual. Severe diarrhoea leads to fluid loss, and may be life-threatening, particularly in young children and people who are malnourished or have impaired immunity.

CHW TASK

Diagnosis, explanation, distribution and administration of treatment for diarrhoea.

CHW DATA POINTS TO COLLECT

- Number of children presenting with diarrhoea who received treatment.
- Number of children presenting presenting with diarrhoea assessed by CHW.

NUMERATOR

Number of children presenting with diarrhoea who received treatment.

DENOMINATOR

Number of children presenting with diarrhoea assessed by CHW.

DISAGGREGATION

Basic

- Geographic area
- Age (0–4 years, 5–9 years)
- Treatment type (oral rehydration salts [ORS] and zinc/ORS/zinc)

Advanced

- Referral
- Sex (male, female)
- SAM, non-SAM
- Socioeconomic status
- Main caregiver's education level

MATURITY LEVEL

A/B.

Longitudinal follow-up is necessary if there is chronic diarrhoea.

FREQUENCY

Monthly.

DIGITALIZATION

Disaggregation can be automatic, especially for age, geographic area, sex and socioeconomic status.

The type of treatment available to CHWs can be presented in a preset menu.

ALIGNMENT

WHO 100 indicators: Coverage of diarrhoea treatment *(1)*

Global Strategy for Women's, Children's and Adolescents' Health: Children with diarrhoea receiving oral rehydration solution (ORS) *(2)*

HDC facility guidance: RMNCAH: Diarrhoea treatment *(3)*

Global Nutrition Monitoring Framework indicators: Children with diarrhoea receiving ORS *(4)*

REFERENCES

1. 2018 global reference list of 100 core health indicators (plus health-related SDGs). Geneva: WHO; 2018 (https://apps.who.int/iris/bitstream/handle/10665/259951/WHO-HIS-IER-GPM-2018.1-eng.pdf, accessed 31 August 2020).
2. Global Health Observatory (GHO) Data [online database]. Global Strategy for Women's, Children's and Adolescents' Health (2016–2030): Data portal. In: World Health Organization [website] (https://www.who.int/gho/publications/gswcah_portal/en/, accessed 31 August 2020).
3. Analysis and use of health facility data: guidance for RMNCAH programme managers. Working Document. October 2019. Geneva: World Health Organization; 2019 (https://www.who.int/healthinfo/FacilityAnalysisGuidance_RMNCAH.pdf, accessed 31 August 2020).
4. Global Nutrition Monitoring Framework: operational guidance for tracking progress in meeting targets for 2025. Geneva: World Health Organization; 2017 (https://www.who.int/publications/i/item/9789241513609, accessed 31 August 2020).

Other

Diarrhoea. In: World Health Organization [website] (https://www.who.int/topics/diarrhoea/en/, accessed 31 August 2020).

71. PROPORTION OF CHILDREN PRESENTING FAST BREATHING AND/OR CHEST INDRAWING

COMMENT

The WHO manual for CHWs[1] highlights fast breathing and chest indrawing as the two critical danger signs in the integrated Community Case Management (iCCM) strategy.

CHW TASK

Assessment for and recognition of fast breathing and/or chest indrawing.

CHW DATA POINTS TO COLLECT

- Number of children presenting fast breathing and/or chest indrawing.
- Number of children screened.

NUMERATOR

Number of children presenting fast breathing and/or chest indrawing.

DENOMINATOR

Number of children screened.

DISAGGREGATION

Basic

- Fast breathing, chest indrawing, both
- Geographic area
- Age (0–11 months, 1–4 years, 5–9 years)
- Sex (male, female)
- Referral

Advanced

- Socioeconomic status (wealth quintile)
- Main caregiver's education level

MATURITY LEVEL

B.

Longitudinal follow-up is necessary to avoid double counting.

FREQUENCY

Monthly.

DIGITALIZATION

Disaggregation can be automatic, especially for age, geographic area, sex, main caregiver's education level and socioeconomic status.

ALIGNMENT

None.

REFERENCES

1. Caring for the sick child in the community. Participant's manual. In: Caring for newborns and children in the community: a training course for community health workers. Geneva: World Health Organization; 2011 (https://apps.who.int/iris/bitstream/handle/10665/44398/9789241548045_Manual_eng.pdf, accessed 31 August 2020).

72. PROPORTION OF CHILDREN RECEIVING ANTIBIOTIC TREATMENT FOR FAST BREATHING AND/OR CHEST INDRAWING

COMMENT

This indicator should be aligned to national guidelines, when CHWs are requested to give antibiotics based on fast breathing and/or chest indrawing.

CHW TASK

Fast breathing and/or chest indrawing recognition and treatment according to national policy.

CHW DATA POINTS TO COLLECT

- Number of children presenting with fast breathing and/or chest indrawing who received antibiotic treatment from CHW.
- Number of children screened.

NUMERATOR

Number of children presenting with fast breathing and/or chest indrawing who received antibiotic treatment from CHW.

DENOMINATOR

Number of children screened.

DISAGGREGATION

Basic

- Fast breathing, chest indrawing, both
- Geographic area
- Age (0–11 months, 1–4 years, 5–9 years)
- Sex (male, female)
- Referral

Advanced

- Treatment type (amoxicillin, cotrimoxazole, other antibiotic)
- Socioeconomic status (wealth quintile)
- Main caregiver's education level

MATURITY LEVEL

B.

Longitudinal follow-up is necessary to avoid double counting.

FREQUENCY

Monthly.

DIGITALIZATION

Disaggregation can be automatic, especially for age, geographic area, sex, main caregiver's education level and socioeconomic status.

The type of treatment available to CHWs can be presented in a preset menu.

ALIGNMENT

HDC facility guidance: RMNCAH: Amoxicillin treatment for pneumonia *(1)*

REFERENCES

1. Analysis and use of health facility data: guidance for RMNCAH programme managers. Working Document. October 2019. Geneva: World Health Organization; 2019 (https://www.who.int/healthinfo/FacilityAnalysisGuidance_RMNCAH.pdf, accessed 31 August 2020).

Other

Caring for the sick child in the community. Participant's manual. In: Caring for newborns and children in the community: a training course for community health workers. Geneva: World Health Organization; 2011 (https://apps.who.int/iris/bitstream/handle/10665/44398/9789241548045_Manual_eng.pdf, accessed 31 August 2020).

73. NUMBER/PROPORTION OF YOUNG INFANTS, 0–59 DAYS OLD WHO RECEIVED PRE-REFERRAL TREATMENT FOR SIGNS OF POSSIBLE SERIOUS BACTERIAL INFECTION

COMMENT

Clear protocols should be in place, ideally based on the WHO guideline on managing possible serious bacterial infection in young infants when referral is not feasible *(1,2)*.

CHW TASK

Recognition of possible serious bacterial infection, administration of pre-referral treatment and referral.

CHW DATA POINTS TO COLLECT

- Number of young infants 0–59 days old who received pre-referral treatment by CHW for signs of possible serious bacterial infection.
- Number of live births in community.

NUMERATOR

Number of young infants 0–59 days old who received pre-referral treatment by CHW for signs of possible serious bacterial infection.

DENOMINATOR

Number of live births in community.

DISAGGREGATION

Basic

- Age (0–6 days, 7–28 days, 29–59 days)
- Geographic area
- Referral
- Type of antibiotics (amoxicillin, gentamycin, other)

Advanced

- Birthweight (< 1000 g, 1000–1499 g, 1500–1999 g, 2000–2499 g)
- Gestational age (preterm status),
- Socioeconomic status (wealth quintile)
- Mother's education level

MATURITY LEVEL

A.

FREQUENCY

Monthly.

DIGITALIZATION

Disaggregation can be automatic, especially for gestational age, geographic area, sex, maternal education level and socioeconomic status. The birthweight group reports can be pulled automatically from the weight filled in by the CHW.

ALIGNMENT

HDC facility guidance: RMNCAH: Newborns treated for neonatal infection *(3)*

REFERENCES

1. Managing possible serious bacterial infection in young infants when referral is not feasible. Geneva: World Health Organization; 2015 (https://apps.who.int/iris/bitstream/handle/10665/181426/9789241509268_eng.pdf, accessed 31 August 2020).
2. WHO/UNICEF Joint statement: Managing possible serious bacterial infection in young infants 0–59 years old when referral is not feasible. Geneva: World Health Organization; 2017 (https://apps.who.int/iris/bitstream/handle/10665/254502/WHO-MCA-17.01-eng.pdf, accessed 31 August 2020).
3. Analysis and use of health facility data: guidance for RMNCAH programme managers. Working Document. October 2019. Geneva: World Health Organization; 2019 (https://www.who.int/healthinfo/FacilityAnalysisGuidance_RMNCAH.pdf, accessed 31 August 2020).2

74. NUMBER/PROPORTION OF CAREGIVERS RECEIVING INFORMATION ON EARLY IDENTIFICATION OF DANGER SIGNS

COMMENT

Counselling on early identification of danger signs should be aligned with national guidance, based on WHO guidelines.

CHW TASK

Counselling on early identification of danger signs.

CHW DATA POINTS TO COLLECT

- Number of caregivers receiving information on early identification of danger signs.
- Number of caregivers of children consulting during the reporting period.

NUMERATOR

Number of caregivers receiving information on early identification of danger signs.

DENOMINATOR

Number of caregivers of children consulting during the reporting period.

DISAGGREGATION

Basic

- Geographic area
- Age
- Sex (male, female)

Advanced

- Socioeconomic status (wealth quintile)
- Main caregiver's education level

MATURITY LEVEL

B.

FREQUENCY

Monthly.

DIGITALIZATION

Disaggregation can be automatic, especially for geographic area, age, sex, socioeconomic status and education level.

ALIGNMENT

None.

REFERENCES

None.

75. PROPORTION OF CHILDREN MONITORED FOR EARLY SIGNS OF DEVELOPMENTAL DELAYS

COMMENT

Children should be monitored for early signs of developmental delays based on developmental risks or milestones as defined by national policy (or WHO windows of achievement).

CHW TASK

Follow-up and monitoring of early signs of developmental delays based on developmental risks or milestones as defined by national policy (or WHO windows of achievement).

CHW DATA POINTS TO COLLECT

Number of children monitored for early signs of developmental delays.

NUMERATOR

Number of children monitored for early signs of developmental delays.

DENOMINATOR

Number of children in the catchment area.

DISAGGREGATION

Basic

- Geographic area
- Age (0–11 months, 1–4 years)
- Sex (male, female)
- Referral

Advanced

- Type of risk
- Socioeconomic status (wealth quintile)
- Education level
- Main caregiver's education level

MATURITY LEVEL

B.

Longitudinal follow-up is necessary.

FREQUENCY

Monthly.

DIGITALIZATION

Disaggregation can be automatic, especially for age, geographic area, sex, main caregiver's education level and socioeconomic status.

Interoperability with facility data could allow knowing when referral has been completed.

ALIGNMENT

None.

REFERENCES

1. Child growth standards. Motor development standards. In: World Health Organization [website] (https://www.who.int/childgrowth/standards/motor_milestones/en/, accessed 31 August 2020).

76. PROPORTION OF CHILDREN WITH SUSPECTED DEVELOPMENTAL DISABILITIES REFERRED

COMMENT

The Global Strategy for Women's, Children's and Adolescents' Health calls for the provision of nurturing care to all children. Childhood developmental disorders and disabilities are a growing challenge to health-care systems around the world – the majority of children with developmental disorders do not have access to care.

The WHO Caregiver Skills Training programme for families of children with developmental delays and disorders *(1)* is available upon request, and should be released soon.

CHW TASK

Identify children with suspected developmental disabilities and refer them for specialist services for assessment, treatment and care.

CHW DATA POINTS TO COLLECT

Number of children with suspected developmental disabilities who are referred.

NUMERATOR

Number of children with suspected developmental disabilities who are referred.

DENOMINATOR

Total number of children who were assessed for their developmental monitoring in the reporting period.

DISAGGREGATION

Basic

- Sex (male, female)
- Age (0–11 months, 1–4 years, 5–9 years, 10–14 years, 15–17 years)
- Geographic area

Advanced

- Socioeconomic status (wealth quintile)
- Education level of main caregiver/parent

MATURITY LEVEL

B.

FREQUENCY

Monthly.

DIGITALIZATION

Disaggregation can be automatic, especially for age, geographic area, sex, education level and socioeconomic status, if feasible.

ALIGNMENT

SDG *(2)*: The SDGs make specific reference to UHC of mental health under target 3.4 (By 2030, reduce by one third premature mortality from NCDs through prevention and treatment and promote mental health and well-being).

Other

In 2013, the World Health Assembly implemented the WHO's comprehensive *Mental Health Action Plan 2013–2020 (3)*, which articulated pragmatic guidelines for the delivery of services, especially in LMICs. The Seventy-second World Health Assembly (2019) extended the period of the action plan to 2030 in order to ensure their alignment with the 2030 Agenda for Sustainable Development. The comprehensive mental health action plan specifies that the early stages of life present a particularly important opportunity to promote mental health and prevent mental disorders. Since up to 50% of mental disorders begin before the age of 14 years, children and adolescents with mental disorders, including those with developmental disorders and disabilities, should be provided with early intervention through evidence-based psychosocial and other nonpharmacological interventions based in the community, avoiding institutionalization and medicalization.

REFERENCES

1. Mental health. Training parents to transform children's lives. In: World Health Organization [website] (https://www.who.int/mental_health/maternal-child/PST/en/, accessed 31 August 2020).
2. Sustainable Development Goals. SDG indicators metadata repository. In: United Nations Statistics Division [website] (https://unstats.un.org/sdgs/metadata/, accessed 31 August 2020).
3. Mental health action plan 2013–2020. Geneva: World Health Organization; 2013 (https://apps.who.int/iris/bitstream/handle/10665/89966/9789241506021_eng.pdf, accessed 31 August 2020).

Other

mhGAP intervention guide for mental, neurological and substance use disorders in non-specialized health settings. Version 2.0. Geneva: World Health Organization; 2016 (https://www.who.int/publications/i/item/mhgap-intervention-guide---version-2.0, accessed 31 August 2020).

77. PROPORTION OF CAREGIVERS BEING COUNSELLED ON RESPONSIVE CAREGIVING AND EARLY LEARNING ACTIVITIES

COMMENT

Counselling on responsive caregiving and early learning activities should be aligned with national guidance, based on the WHO guideline on improving early childhood development *(1)* and the Nurturing Care Framework for ECD *(2)*.

CHW TASK

Counselling on responsive caregiving and early learning activities.

CHW DATA POINTS TO COLLECT

- Number of caregivers receiving counselling on responsive caregiving and early learning activities.
- Number of caregivers of children consulting during the reporting period.

NUMERATOR

Number of caregivers receiving counselling on responsive caregiving and early learning activities.

DENOMINATOR

Number of caregivers of children consulting during the reporting period.

DISAGGREGATION

Basic

- Geographic area
- Age (0–11 months, 1–4 years)
- Sex (male, female, other)

Advanced

- Socioeconomic status (wealth quintile)
- Main caregiver's education level

MATURITY LEVEL

B.

FREQUENCY

Monthly.

DIGITALIZATION

Disaggregation can be automatic, especially for geographic area, age, sex, socioeconomic status and education level.

ALIGNMENT

None.

REFERENCES

1. Improving early childhood development: WHO guideline. Geneva: World Health Organization; 2020 (https://www.who.int/publications/i/item/97892400020986, accessed 31 August 2020).
2. World Health Organization, United Nations Children's Fund, World Bank Group. Nurturing care for early childhood development: a framework for helping children survive and thrive to transform health and human potential. Geneva: World Health Organization; 2018 (https://apps.who.int/iris/bitstream/handle/10665/272603/9789241514064-eng.pdf, accessed 31 August 2020).

Other

Reports & Working Papers. In: Harvard University, Center on the Developing Child [website] (https://developingchild.harvard.edu/resourcecategory/reports-and-working-papers/, accessed 31 August 2020).

78. PROPORTION OF CHILDREN WITH SUSPECTED DEVELOPMENTAL DISORDERS AND DISABILITIES WHOSE CAREGIVERS RECEIVE PARENTING INFORMATION

COMMENT

The Global Strategy for Women's, Children's and Adolescents' Health calls for the provision of nurturing care to all children. Childhood developmental disorders and disabilities are a growing challenge to health-care systems around the world – the majority of children with developmental disorders do not have access to care.

Given the additional challenges that they experience, caregivers of children with developmental delays or disorders should be specifically supported in providing nurturing care within a "whole family" approach.

The WHO Caregiver Skills Training programme for families of children with developmental delays and disorders *(1)* is available upon request, and should be released soon.

CHW TASK

Identify children with suspected developmental disorders and disabilities and provide their caregivers with information on parenting.

CHW DATA POINTS TO COLLECT

Number of children with suspected developmental disorders and disabilities whose caregivers receive information on parenting.

NUMERATOR

Number of children with suspected developmental disorders and disabilities whose caregivers receive information on parenting.

DENOMINATOR

Total number of children who were assessed for their developmental disorders and disabilities in the past 12 months.

DISAGGREGATION

Basic

- Sex (male, female)
- Age (0–11 months, 1–4 years, 5–9 years, 10–14 years, 15–17 years)
- Geographic area

Advanced

- Socioeconomic status (wealth quintile)
- Education level of main caregiver/parent

MATURITY LEVEL

B.

FREQUENCY

Monthly.

DIGITALIZATION

Disaggregation can be automatic, especially for age, geographic area, sex, education level and socioeconomic status, if feasible.

ALIGNMENT

SDG (2): The SDGs make specific reference to UHC of mental health under target 3.4 (By 2030, reduce by one third premature mortality from NCDs through prevention and treatment and promote mental health and well-being).

Other

In 2013, the World Health Assembly implemented the WHO's comprehensive Mental Health Action Plan 2013–2020 (3), which articulated pragmatic guidelines for the delivery of services, especially in LMICs. The Seventy-second World Health Assembly (2019) extended the period of the action plan to 2030 in order to ensure their alignment with the 2030 Agenda for Sustainable Development. The comprehensive mental health action plan specifies that the early stages of life present a particularly important opportunity to promote mental health and prevent mental disorders. Since up to 50% of mental disorders begin before the age of 14 years, children and adolescents with mental disorders, including those with developmental disorders and disabilities, should be provided with early intervention through evidence-based psychosocial and other nonpharmacological interventions based in the community, avoiding institutionalization and medicalization.

REFERENCES

1. Mental health. Training parents to transform children's lives. In: World Health Organization [website] (https://www.who.int/mental_health/maternal-child/PST/en/, accessed 31 August 2020).
2. Sustainable Development Goals. SDG indicators metadata repository. In: United Nations Statistics Division [website] (https://unstats.un.org/sdgs/metadata/, accessed 31 August 2020).
3. Mental health action plan 2013–2020. Geneva: World Health Organization; 2013 (https://apps.who.int/iris/bitstream/handle/10665/89966/9789241506021_eng.pdf, accessed 31 August 2020).

Other

mhGAP intervention guide for mental, neurological and substance use disorders in non-specialized health settings. Version 2.0. Geneva: World Health Organization; 2016 (https://www.who.int/publications/i/item/mhgap-intervention-guide---version-2.0, accessed 31 August 2020).

79. NUMBER OF PEOPLE REFERRED FOR HIV TESTING

COMMENT

Depending upon the availability of rapid testing for CHWs, this indicator or the indicator on rapid HIV testing by CHWs can be prioritized. The UNICEF publication *Working to end AIDS for every child (1)* stresses that both HIV testing and treatment rates for children and adolescents are lagging well behind those for adults. For children living with HIV, nearly half do not receive treatment, while others receive it too late .

The WHO Global Health Sector Strategy on HIV 2016–2020 stresses that new HIV testing approaches, including self- and community-based testing, and new quality-assured testing technologies, promise to identify and link greater numbers of people living with HIV to early treatment and care, maximizing HIV prevention potential and treatment effectiveness.

CHW TASK

Referral of people for HIV testing.

CHW DATA POINTS TO COLLECT

Number of people age > 18 months who were referred for an HIV test.

NUMERATOR

Number of people age > 18 months who were referred for an HIV test. People tested should only be counted once.

DENOMINATOR

Number of people aged more than 18 months in the catchment area.

DISAGGREGATION

Basic

- Age (1.5–4, 5–9, 10–14, 15–19, 20–24, 25–49, 50+)
- Gender (male, female, transgender)
- Geographic area

Advanced

- HIV test: Positive, negative, indeterminate or rejected for testing
- Socioeconomic status (wealth quintile)
- Main caregiver's education level

MATURITY LEVEL

C.

Longitudinal follow-up is necessary, as well as interoperability of records between referral structures for HIV status.

FREQUENCY

Monthly.

DIGITALIZATION

None.

ALIGNMENT

WHO Consolidated strategic information guidelines for HIV in the health sector: People with HIV *(2)*

REFERENCES

1. For every child, end AIDS: seventh stocktaking report. New York: UNICEF; 2016 (https://www.unicef.org/publications/index_93427.html, accessed 31 August 2020).
2. Consolidated HIV strategic information guidelines: driving impact through programme monitoring and management. Geneva: World Health Organization; 2020 (https://apps.who.int/iris/bitstream/handle/10665/331697/9789240000735-eng.pdf, accessed 31 August 2020).

80. INSUFFICIENT PHYSICAL ACTIVITY AMONG CHILDREN (0 TO LESS THAN 5 YEARS OF AGE)

COMMENT

The WHO guidelines on physical activity, sedentary behaviour and sleep for children under 5 years of age recommend that *(1)*:

- Infants (less than 1 year) should be physically active several times a day in a variety of ways, particularly through interactive floor-based play; more is better. For those not yet mobile, this includes at least 30 minutes in prone position (tummy time) spread throughout the day while awake.
- Children 1–2 years of age should spend at least 180 minutes in a variety of types of physical activities at any intensity, including moderate- to vigorous-intensity physical activity, spread throughout the day; more is better.
- Children 3–4 years of age should spend at least 180 minutes in a variety of types of physical activities at any intensity, of which at least 60 minutes is moderate- to vigorous-intensity physical activity, spread throughout the day; more is better.

The CHW should ask parents of the child on how many days children were physically active in the last week and see if they met WHO recommendations on physical activity for their age.

CHW TASK

Recommendation and follow-up on physical activity for children less than 5 years of age.

CHW DATA POINTS TO COLLECT

Number of children less than 5 not meeting WHO recommendations on physical activity for their age group.

NUMERATOR

Number of children less than 5 not meeting WHO recommendations on physical activity for their age group.

DENOMINATOR

Number of children less than 5 in the catchment area.

DISAGGREGATION

Basic

- Geographic area
- Age (0–11 months, 1–2 years, 3–4 years)
- Sex (male, female)

Advanced

- Socioeconomic status (wealth quintile)

MATURITY LEVEL

B.

Longitudinal follow-up is necessary.

FREQUENCY

At least once a year.

DIGITALIZATION

Disaggregation can be automatic, especially for age, geographic area, sex and socioeconomic status, if feasible.

ALIGNMENT

WHO Guidelines on physical activity, sedentary behaviour and sleep for children under 5 years of age *(1)*

REFERENCES

1. Guidelines on physical activity, sedentary behaviour and sleep for children under 5 years of age. Geneva: World Health Organization; 2019 (https://www.who.int/publications/i/item/guidelines-on-physical-activity-sedentary-behaviour-and-sleep-for-children-under-5-years-of-age, accessed 31 August 2020).

81. INSUFFICIENT PHYSICAL ACTIVITY AMONG CHILDREN (5 TO LESS THAN 10 YEARS OF AGE)

COMMENT

The WHO guidelines on global recommendations on physical activity for health[1] recommend that:

- Children and young people aged 5–17 years old should accumulate at least 60 minutes of moderate- to vigorous-intensity physical activity daily.
- Physical activity of amounts greater than 60 minutes daily will provide additional health benefits.

WHO will be releasing updated guidelines late 2020.

The CHW should ask children on how many days they were physically active in the last week and see if they met WHO recommendations on physical activity for their age.

CHW TASK

Recommendation and follow-up on physical activity for children 5 to less than 10 years of age.

CHW DATA POINTS TO COLLECT

Number of children 5 to less than 10 years of age not meeting WHO recommendations on physical activity for their age group.

NUMERATOR

Number of children 5 to less than 10 years of age not meeting WHO recommendations on physical activity for their age group.

DENOMINATOR

Number of children 5 to less than 10 years in the catchment area.

DISAGGREGATION

Basic

- Geographic area
- Age
- Sex (male, female)

Advanced

- Socioeconomic status (wealth quintile)

MATURITY LEVEL

B.

Longitudinal follow-up is necessary.

FREQUENCY

At least once a year.

DIGITALIZATION

Disaggregation can be automatic, especially for age, geographic area, sex and socioeconomic status, if feasible.

ALIGNMENT

WHO Global recommendations on physical activity for health *(1)*

REFERENCES

1. Global recommendations on physical activity for health. Geneva: World Health Organization; 2010 (https://www.who.int/dietphysicalactivity/publications/9789241599979/en/, accessed 31 August 2020).

82. NUMBER OF YOUNG ADOLESCENT DEATHS (10–14 YEARS OLD)

COMMENT

Feasibility of reporting adolescent deaths will depend on the catchment area (size, access, etc.). Adolescent deaths must be reported with the age of the adolescent (verified or suspected). The same form should be used to collect at household level all deaths, with age, sex, pregnancy-related cause, or other cause, which can then be used to inform this indicator.

CHW TASK

Death notification.

Identification of an adolescent death.

CHW DATA POINTS TO COLLECT

Number of new young adolescent deaths (10–14 years old) in the reporting period.

NUMERATOR

Number of new young adolescent deaths (10–14 years old) in the reporting period.

DENOMINATOR

None.

DISAGGREGATION

Basic

- Geographic area
- Place of occurrence and place of usual residence
- Sex (male, female, other)
- Age

Advanced

- Maternal or main caregiver's wealth
- Ethnic group
- Migratory status

MATURITY LEVEL

A.

FREQUENCY

At least once a year.

DIGITALIZATION

Interoperability with death notification services would allow better case review.

Disaggregation can be automatic, especially for age, sex, geographic area, or main caregiver's education level, ethnic group and socioeconomic status, if feasible.

ALIGNMENT

WHO 100 indicators: Adolescent mortality rate *(1)*

Global Strategy for Women's, Children's and Adolescents' Health: Adolescent mortality rate *(2)*

HDC facility guidance: Adolescent deaths in health facility *(3)*

REFERENCES

1. 2018 global reference list of 100 core health indicators (plus health-related SDGs). Geneva: WHO; 2018 (https://apps.who.int/iris/bitstream/handle/10665/259951/WHO-HIS-IER-GPM-2018.1-eng.pdf, accessed 31 August 2020).
2. Global Health Observatory (GHO) Data [online database]. Global Strategy for Women's, Children's and Adolescents' Health (2016–2030): Data portal. In: World Health Organization [website] (https://www.who.int/gho/publications/gswcah_portal/en/, accessed 31 August 2020).
3. Analysis and use of health facility data. In: World Health Organization [website] (https://www.who.int/healthinfo/tools_data_analysis_routine_facility/en/, accessed 31 August 2020).

83. NUMBER OF OLDER ADOLESCENT DEATHS (15–19 YEARS OLD)

COMMENT

Feasibility of reporting adolescent deaths will depend on the catchment area (size, access, etc.). Adolescent deaths must be reported with the age of the adolescent (verified or suspected). The same form should be used to collect at household level all deaths, with age, sex, pregnancy-related cause, or other cause, which can then be used to inform this indicator.

CHW TASK

Death notification.

Identification of an adolescent death.

CHW DATA POINTS TO COLLECT

Number of new older adolescent deaths (15–19 years old) in the reporting period.

NUMERATOR

Number of new older adolescent deaths (15–19 years old) in the reporting period.

DENOMINATOR

None.

DISAGGREGATION

Basic

- Geographic area
- Place of occurrence and place of usual residence
- Sex (male, female, other)
- Age (it is recommended to record the precise age counted in years)
- If age groups must be used, consider these age groups:
  - 15 to less than 18 years old
  - 18 to less than 20 years old
- The international definition of a child is up to 18 but older adolescents are counted as 15 to less than 20.

Advanced

- Maternal or main caregiver's wealth
- Ethnic group
- Migratory status

MATURITY LEVEL

A.

FREQUENCY

At least once a year.

DIGITALIZATION

Interoperability with death notification services would allow better case review.

Disaggregation can be automatic, especially for age, sex, geographic area, maternal or main caregiver's education level, ethnic group and socioeconomic status, if feasible.

ALIGNMENT

WHO 100 indicators: Adolescent mortality rate *(1)*

Global Strategy for Women's, Children's and Adolescents' Health: Adolescent mortality rate *(2)*

HDC facility guidance: Adolescent deaths in health facility *(3)*

REFERENCES

1. 2018 global reference list of 100 core health indicators (plus health-related SDGs). Geneva: WHO; 2018 (https://apps.who.int/iris/bitstream/handle/10665/259951/WHO-HIS-IER-GPM-2018.1-eng.pdf, accessed 31 August 2020).
2. Global Health Observatory (GHO) Data [online database]. Global Strategy for Women's, Children's and Adolescents' Health (2016–2030): Data portal. In: World Health Organization [website] (https://www.who.int/gho/publications/gswcah_portal/en/, accessed 31 August 2020).
3. Analysis and use of health facility data. In: World Health Organization [website] (https://www.who.int/healthinfo/tools_data_analysis_routine_facility/en/, accessed 31 August 2020).

84. SUPPLEMENTATION WITH IRON-CONTAINING SUPPLEMENTS (AND FOLIC ACID) TO ADOLESCENT GIRLS AND WOMEN OF REPRODUCTIVE AGE FOR ANAEMIA PREVENTION

COMMENT

In populations where the prevalence of anaemia among nonpregnant women of reproductive age is 20% or higher, intermittent iron and folic acid supplementation is recommended as a public health intervention in menstruating women, to improve their haemoglobin concentrations and iron status and thereby reduce the risk of anaemia.

While school is a primary platform for iron and folic acid supplementation programmes targeting adolescent girls, those out of school are often at greatest risk. CHWs would therefore play a critical role in iron and folic acid supplementation provision.

CHW TASK

Provision and monitoring of iron and folic acid supplementation for adolescent girls and menstruating women

CHW DATA POINTS TO COLLECT

- Number of adolescent girls and menstruating women in the reporting period who received, were prescribed, or already have iron and folic acid–containing supplements.
- Number of consultations with adolescent girls and menstruating women in the reporting period

NUMERATOR

Number of adolescent girls and menstruating women in the reporting period who received, were prescribed, or already have iron and folic acid–containing supplements.

DENOMINATOR

Number of consultations with adolescent girls and menstruating women in the reporting period.

DISAGGREGATION

Basic

- Geographic area
- Age (age groups 10–14, 15–19, 20–49)

Advanced

- None

MATURITY LEVEL

A.

FREQUENCY

Monthly.

DIGITALIZATION

Adolescent girls and women could be tracked with a unique identifier. Alerts can be set for women who need to receive additional supplements or prescription.

ALIGNMENT

None.

REFERENCES

1. e-Library of Evidence for Nutrition Actions (eLENA): Intermittent iron and folic acid supplementation in menstruating women. Guidance summary. In: World Health Organization [website] (https://www.who.int/elena/titles/guidance_summaries/iron_women/en/, accessed 31 August 2020).

85. WOMEN AND ADOLESCENT GIRLS WHO ARE UNDERWEIGHT

CHW TASK

Measurement of height and weight.

CHW DATA POINTS TO COLLECT

Weight and height of non-pregnant women aged 15–49 years.

NUMERATOR

Number of non-pregnant women and adolescent girls with low BMI (< 18.5 kg/m^2).

DENOMINATOR

Number of non-pregnant women and adolescent girls in the catchment area.

DISAGGREGATION

Basic

- Geographic area
- Age (age groups 10–14, 15–17, 18–19 should be considered for adolescents)

Advanced

- Socioeconomic status (wealth quintile)
- Education level

MATURITY LEVEL

B

Longitudinal follow-up is necessary.

FREQUENCY

Monthly if reporting based on consultations. Less frequently (at least once a year) if reported by household assessment.

DIGITALIZATION

BMI could be automatically calculated with feedback on results.

Disaggregation can be automatic, especially for age, geographic area, education level and socioeconomic status.

ALIGNMENT

WHO Global Nutrition Monitoring Framework: Low BMI in women aged 15–49 years *(1)*

REFERENCES

1. Global Nutrition Monitoring Framework: operational guidance for tracking progress in meeting targets for 2025. Geneva: World Health Organization; 2017 (https://www.who.int/publications/i/item/9789241513609, accessed 31 August 2020).

86. INSUFFICIENT PHYSICAL ACTIVITY AMONG ADOLESCENTS

COMMENT

The *WHO Guidelines on global recommendations on physical activity for health (1)* recommend that:

- Children and young people aged 5–17 years old should accumulate at least 60 minutes of moderate- to vigorous-intensity physical activity daily.
- Physical activity of amounts greater than 60 minutes daily will provide additional health benefits.

WHO will be releasing updated guidelines late 2020.

The CHW should ask adolescents on how many days they were physically active in the last week and see if they met WHO recommendations on physical activity for their age.

CHW TASK

Recommendation and follow-up on physical activity.

CHW DATA POINTS TO COLLECT

Number of adolescents not meeting WHO recommendations on physical activity for health.

NUMERATOR

Number of adolescents not meeting WHO recommendations on physical activity for health, i.e. doing less than 60 minutes of moderate- to vigorous-intensity physical activity daily.

DENOMINATOR

Number of adolescents in the catchment area.

DISAGGREGATION

Basic

- Geographic area
- Age (10–14, 15–19)
- Sex (male, female, intersex)

Advanced

- Socioeconomic status (wealth quintile)
- Type and length of physical activity
- Attending school or not

MATURITY LEVEL

B.

Longitudinal follow-up is necessary.

FREQUENCY

At least once a year.

DIGITALIZATION

Disaggregation can be automatic, especially for age, geographic area, sex, school attendance and socioeconomic status, if feasible.

The type and length of physical activity should be presented in a preset menu.

ALIGNMENT

WHO 100 indicators: Insufficient physical activity in adults (Also: adolescents) *(2)*

Global Strategy for Women's, Children's and Adolescents' Health: Prevalence of insufficient physical activity among school going adolescents aged 11–17 years *(3)*

WHO NCD Global Monitoring Framework: Prevalence of insufficiently physically active adolescents, defined as less than 60 minutes of moderate- to vigorous-intensity activity daily *(4)*

REFERENCES

1. Global recommendations on physical activity for health. Geneva: World Health Organization; 2010 (https://www.who.int/dietphysicalactivity/factsheet_recommendations/en/, accessed 31 August 2020).
2. 2018 global reference list of 100 core health indicators (plus health-related SDGs). Geneva: WHO; 2018 (https://apps.who.int/iris/bitstream/handle/10665/259951/WHO-HIS-IER-GPM-2018.1-eng.pdf, accessed 31 August 2020).
3. Global Health Observatory (GHO) Data [online database]. Global Strategy for Women's, Children's and Adolescents' Health (2016–2030): Data portal. In: World Health Organization [website] (https://www.who.int/gho/publications/gswcah_portal/en/, accessed 31 August 2020).
4. NCD Global Monitoring Framework. In: World Health Organization [website] (https://www.who.int/nmh/global_monitoring_framework/en/, accessed 31 August 2020).

87. PROPORTION OF ADOLESCENTS CURRENTLY USING TOBACCO

COMMENT

In certain countries, it will be essential to obtain the agreement of parents before asking questions to adolescents. In any case, **confidentiality** is essential. This question should not be asked in front of other people, but individually in a confidential setting. The results should not be shared with the parents. Please refer to section 7.5.4 on confidentiality in the main text of this guidance. Confidentiality may impact the result of this indicator. Therefore, countries should evaluate whether this indicator is needed, taking into account confidentiality, whether the same question is asked in school surveys or other surveys, and whether triangulation of data would be helpful.

This indicator for the age 15–18 overlaps with the indicator SDG 3.a.1, so they should be articulated together (see NCD module).

CHW TASK

Community interventions to stop tobacco use and follow-up on consumption.

CHW DATA POINTS TO COLLECT

Number of current adolescent tobacco users.

NUMERATOR

Number of current adolescent tobacco users. "Current users" includes both daily and non-daily users of smoked or smokeless tobacco in the previous 30 days.

DENOMINATOR

Number of people aged 10–19 years.

DISAGGREGATION

Basic

- Geographic area
- Age (10–14, 15–19)
- Sex
- Tobacco use (smoked and/or smokeless tobacco) (daily or non-daily)

Advanced

- Socioeconomic status (wealth quintile)
- Education level
- Smoked tobacco products: Cigarettes, cigarillos, cigars, cheroots, bidis, pipes, shisha (water pipes), roll-your-own tobacco, kretek and any other form of tobacco that is consumed by smoking
- Smokeless tobacco product: Moist snuff, creamy snuff, dry snuff, plug, dissolvables, gul, loose leaf, red tooth powder, snus, chimo, gutkha, khaini, gudakhu, zarda, quiwam, dohra, tuibur, nasway, naas, naswar, shammah, toombak, paan (betel quid with tobacco), iq'mik, mishri, tapkeer, tombol and any other tobacco product that is consumed by sniffing, holding in the mouth or chewing

MATURITY LEVEL

B.

Longitudinal follow-up is necessary.

FREQUENCY

At least once a year.

DIGITALIZATION

Disaggregation can be automatic, especially for age, geographic area, sex, education level and socioeconomic status.

The type of tobacco use could be presented in a preset menu.

ALIGNMENT

SDG: 3.a.1: Age-standardized prevalence of current tobacco use among persons aged 15 years and older *(1)*

WHO 100 indicators: Tobacco use among persons aged 15+ years *(2)*

WHO NCD Global Monitoring Framework: Prevalence of current tobacco use among adolescents *(3)*

REFERENCES

1. Sustainable Development Goals. SDG indicators metadata repository. In: United Nations Statistics Division [website] (https://unstats.un.org/sdgs/metadata/, accessed 31 August 2020).
2. 2018 global reference list of 100 core health indicators (plus health-related SDGs). Geneva: WHO; 2018 (https://apps.who.int/iris/bitstream/handle/10665/259951/WHO-HIS-IER-GPM-2018.1-eng.pdf, accessed 31 August 2020).
3. NCD Global Monitoring Framework. In: World Health Organization [website] (https://www.who.int/nmh/global_monitoring_framework/en/, accessed 31 August 2020).

88. PROPORTION OF ALCOHOL CONSUMERS

COMMENT

Alcohol use in the past 12 months is defined as the proportion of people in a given population who have consumed any alcohol during the past 12 months, assessed at a given point in time. The number of drinkers in the past 12 months provides important information by separating out the drinking from the nondrinking population.

Data collection tools to inform the questions on the past 12 months drinking are available here:
https://www.who.int/ncds/surveillance/steps/instrument/STEPS_Instrument_V3.2.pdf *(1)*
and
https://www.who.int/ncds/surveillance/gshs/GSHS_Core_Modules_2013_English.pdf *(2)*

Show cards can also be of use.

CHW TASK

Identification of people who have consumed alcohol in the previous 12 months based on a simple question to their clients.

CHW DATA POINTS TO COLLECT

Number of people reported using alcohol for 12-month period.

NUMERATOR

The number of people reported using alcohol in the past 12 months.

DENOMINATOR

The total number of people responding to the corresponding question.

DISAGGREGATION

Basic

- Gender (male, female, transgender)
- Pregnancy, postpartum
- Age (10–14, 15–19, 20+)
- Geographic area
- Sub-populations with comorbid conditions (HIV, TB, NTDs)

Advanced

- Socioeconomic status (wealth quintile)
- Education level

MATURITY LEVEL

B.

FREQUENCY

At least once a year.

DIGITALIZATION

Disaggregation can be automatic, especially for age, geographic area, sex, education level and socioeconomic status, if feasible.

ALIGNMENT

SDG *(3)*: The SDGs make specific reference to prevention and treatment of substance abuse in its target 3.5. Alcohol consumption is specifically addressed in SDG indicator 3.5.2 on alcohol consumption: "Alcohol per capita consumption (aged 15 years and older) within a calendar year in litres of pure alcohol".

WHO 100 indicators: Total alcohol per capita (age 15+ years) consumption *(4)*

WHO NCD Global Monitoring Framework: Harmful use of alcohol *(5)*

REFERENCES

1. WHO STEPS instrument. The WHO STEPwise approach to noncommunicable disease risk factor surveillance (STEPS). Geneva: World Health Organization; n.d. (https://www.who.int/ncds/surveillance/steps/instrument/STEPS_Instrument_V3.2.pdf, accessed 31 August 2020).
2. Global School-based Student Health Survey (GSHS). 2013 core questionnaire modules. Geneva: World Health Organization; 2013 (https://www.who.int/ncds/surveillance/gshs/GSHS_Core_Modules_2013_English.pdf, accessed 31 August 2020).
3. Sustainable Development Goals. SDG indicators metadata repository. In: United Nations Statistics Division [website] (https://unstats.un.org/sdgs/metadata/, accessed 31 August 2020).
4. 2018 global reference list of 100 core health indicators (plus health-related SDGs). Geneva: WHO; 2018 (https://apps.who.int/iris/bitstream/handle/10665/259951/WHO-HIS-IER-GPM-2018.1-eng.pdf, accessed 31 August 2020).
5. NCD Global Monitoring Framework. In: World Health Organization [website] (https://www.who.int/nmh/global_monitoring_framework/en/, accessed 31 August 2020).

Other

Global Information System on Alcohol and Health (GISAH). In: World Health Organization [website] (https://www.who.int/substance_abuse/activities/gisah/en/, accessed 31 August 2020).

Indicator Code Book: Global Information System on Alcohol and Health. Geneva: World Health Organization; 2014 (https://www.who.int/substance_abuse/activities/gisah_indicatorbook.pdf, accessed 31 August 2020).

89. PROPORTION OF PEOPLE WITH HEAVY EPISODIC DRINKING

COMMENT

Heavy episodic drinking is defined as the proportion of people who have had at least 60 g or more of pure alcohol on at least one occasion in the past 12 months.

A consumption of 60 g of pure alcohol corresponds approximately to six standard alcoholic drinks.

Show cards can be used to facilitate the understanding of what constitutes a single standard drink.

In certain countries, it will be essential to obtain the agreement of parents before asking questions to adolescents. In any case, confidentiality is essential. This question should not be asked in front of other people, but individually in a confidential setting. The results should not be shared with the parents. Please refer to section 7.5.4 in the main text of this guidance on confidentiality.

CHW TASK

Identification of people who have had at least 60 g or more of pure alcohol on at least one occasion in the past 12 months.

CHW DATA POINTS TO COLLECT

Number of people reported heavy episodic drinking in the past 12 months.

NUMERATOR

Number of respondents who reported drinking 60 g or more of pure alcohol on at least one occasion in the past 12 months.

DENOMINATOR

The total number of respondents.

DISAGGREGATION

Basic

- Gender (male, female, transgender)
- Pregnancy, postpartum
- Age (10–14, 15–19, 20+)
- Geographic area
- Sub-populations with comorbid conditions (HIV, TB, NTDs)

Advanced

- Socioeconomic status (wealth quintile)
- Education level

MATURITY LEVEL

B.

FREQUENCY

At least once a year.

DIGITALIZATION

Disaggregation can be automatic, especially for age, geographic area, sex, education level and socioeconomic status, if feasible.

ALIGNMENT

SDG *(1)*: The SDGs make specific reference to prevention and treatment of substance abuse in its target 3.5. Alcohol consumption is specifically addressed in SDG indicator 3.5.2 on alcohol consumption: "Alcohol per capita consumption (aged 15 years and older) within a calendar year in litres of pure alcohol".

WHO 100 indicators: Total alcohol per capita (age 15+ years) consumption *(2)*

WHO NCD Global Monitoring Framework: Age-standardized prevalence of heavy episodic drinking among adolescents and adults, as appropriate, within the national context *(3)*

REFERENCES

1. Sustainable Development Goals. SDG indicators metadata repository. In: United Nations Statistics Division [website] (https://unstats.un.org/sdgs/metadata/, accessed 31 August 2020).
2. 2018 global reference list of 100 core health indicators (plus health-related SDGs). Geneva: WHO; 2018 (https://apps.who.int/iris/bitstream/handle/10665/259951/WHO-HIS-IER-GPM-2018.1-eng.pdf, accessed 31 August 2020).
3. NCD Global Monitoring Framework. In: World Health Organization [website] (https://www.who.int/nmh/global_monitoring_framework/en/, accessed 31 August 2020).

Other

Global Information System on Alcohol and Health (GISAH). In: World Health Organization [website] (https://www.who.int/substance_abuse/activities/gisah/en/, accessed 31 August 2020).

Indicator Code Book: Global Information System on Alcohol and Health. Geneva: World Health Organization; 2014 (https://www.who.int/substance_abuse/activities/gisah_indicatorbook.pdf, accessed 31 August 2020).

90. PROPORTION OF PEOPLE WHO USE PSYCHOACTIVE DRUGS

COMMENT

The percentage of people who have taken any psychoactive drugs in the last 12 months. This includes using cannabis (marijuana, pot, grass, hash, etc.), cocaine (coke, crack, etc.), amphetamine-type stimulants (speed, meth, ecstasy, etc.), inhalants (nitrous, glue, petrol, paint thinner, etc.), sedatives and sleeping pills (diazepam, alprazolam, flunitrazepam, midazolam, etc.), hallucinogens (LSD, acid, mushrooms, trips, ketamine, etc.), opioids (heroin, morphine, methadone, buprenorphine, codeine, etc.).

CHW TASK

Identification of people who report use of any psychoactive drugs in the past 12 months.

CHW DATA POINTS TO COLLECT

Number of people who report use of any psychoactive drugs in the past 12 months.

NUMERATOR

Number of people who report use of any psychoactive drugs in the past 12 months.

DENOMINATOR

The total number of people responding to the corresponding question(s).

DISAGGREGATION

Basic

- Gender (male, female, transgender)
- Pregnancy, postpartum
- Age (10–14, 15–19, 20+)
- Geographic area
- Sub-populations with comorbid conditions (HIV, TB, NTDs)
- Type of drugs: cannabis, opioids, cocaine, amphetamine-type stimulants

Advanced

- Socioeconomic status (wealth quintile)
- Education level

MATURITY LEVEL

B.

FREQUENCY

At least once a year.

DIGITALIZATION

Disaggregation can be automatic, especially for age, geographic area, sex, education level and socioeconomic status, if feasible.

ALIGNMENT

SDG: 3.5: Strengthen the prevention and treatment of substance abuse, including narcotic drug abuse and harmful use of alcohol *(1)*

REFERENCES

1. Sustainable Development Goals. SDG indicators metadata repository. In: United Nations Statistics Division [website] (https://unstats.un.org/sdgs/metadata/, accessed 31 August 2020).

Other

World Drug Report 2020. Vienna: United Nations Office on Drugs and Crime; 2020 (https://wdr.unodc.org/wdr2020/, accessed 31 August 2020).

91. PROPORTION OF PEOPLE WHO INJECT PSYCHOACTIVE DRUGS

CHW TASK

Identification of people who have reported injecting drug use in the past 12 months.

CHW DATA POINTS TO COLLECT

Number of people who have reported injecting drug use in the past 12 months.

NUMERATOR

Number of people who have reported injecting drug use in the past 12 months.

DENOMINATOR

The total number of people responding to the corresponding question(s).

DISAGGREGATION

Basic

- Gender (male, female, transgender)
- Pregnancy, postpartum
- Age (10–14, 15–19, 20+)
- Geographic area
- Sub-populations with comorbid conditions (HIV, TB, NTDs)
- Type of drugs: cannabis, opioids, cocaine, amphetamine-type stimulants

Advanced

- Socioeconomic status (wealth quintile)
- Education level

MATURITY LEVEL

B.

FREQUENCY

At least once a year.

DIGITALIZATION

Disaggregation can be automatic, especially for age, geographic area, sex, education level and socioeconomic status, if feasible.

ALIGNMENT

SDG: 3.5: Strengthen the prevention and treatment of substance abuse, including narcotic drug abuse and harmful use of alcohol *(1)*

REFERENCES

1. Sustainable Development Goals. SDG indicators metadata repository. In: United Nations Statistics Division [website] (https://unstats.un.org/sdgs/metadata/, accessed 31 August 2020).

Other

World Drug Report 2020. Vienna: United Nations Office on Drugs and Crime; 2020 (https://wdr.unodc.org/wdr2020/, accessed 31 August 2020).

92. NUMBER OF PEOPLE WITH SUICIDAL IDEATION OR PLAN

COMMENT

Mental disorders contribute to 7% of the global burden of diseases and have significant impacts on health and major social, human rights and economic consequences in all countries of the world. Approximately half of all mental disorders start by age 14, and suicide is the second leading cause of death in young people aged 15–29.

Suicides and suicide attempts have a ripple effect that impacts families, friends, colleagues, communities and societies. Suicides are preventable.

WHO has published a mhGAP community toolkit *(1)* that can be used as a reference tool for the assessment of MNS disorders/mental health conditions by CHWs, including for exploring suicide ideation.

Confidentiality (see the mhGAP toolkit and section 7.5.4 in the main text of this guidance) and parental consent for adolescents according to national policy should be ensured.

CHW TASK

Identify and record people with suicidal ideation or plan.

CHW DATA POINTS TO COLLECT

Number of people with suicidal ideation or plan.

NUMERATOR

Number of people with suicidal ideation or plan.

DENOMINATOR

Number of people assessed.

DISAGGREGATION

Basic

- Gender (male, female, transgender)
- Pregnancy, postpartum
- Age (10–14, 15–19, 20+)
- Geographic area

Advanced

- Socioeconomic status (wealth quintile)
- Education level

MATURITY LEVEL

B.

FREQUENCY

Monthly.

DIGITALIZATION

Disaggregation can be automatic, especially for age, geographic area, sex, education level and socioeconomic status, if feasible.

ALIGNMENT

SDG *(2)*: The SDGs make specific reference to UHC of mental health under target 3.4 (By 2030, reduce by one third premature mortality from NCDs through prevention and treatment and promote mental health and well-being), including 3.4.2 on suicide prevention.

WHO 100 indicators: Includes suicide rate, but not suicide attempts or ideation *(3)*

Other

In 2013, the World Health Assembly implemented the WHO's comprehensive *Mental Health Action Plan 2013–2020 (4)*, which articulated pragmatic guidelines for the delivery of services, especially in LMICs. The action plan includes a target to reduce the rate of suicide in countries by 10% [by the year 2020]. The Seventy-second World Health Assembly (2019) extended the period of the action plan to 2030 in order to ensure their alignment with the 2030 Agenda for Sustainable Development.

REFERENCES

1. mhGAP community toolkit: field test version. Geneva: World Health Organization; 2019 (https://www.who.int/publications/i/item/the-mhgap-community-toolkit-field-test-version, accessed 31 August 2020).
2. Sustainable Development Goals. SDG indicators metadata repository. In: United Nations Statistics Division [website] (https://unstats.un.org/sdgs/metadata/, accessed 31 August 2020).
3. 2018 global reference list of 100 core health indicators (plus health-related SDGs). Geneva: WHO; 2018 (https://apps.who.int/iris/bitstream/handle/10665/259951/WHO-HIS-IER-GPM-2018.1-eng.pdf, accessed 31 August 2020).
4. Mental health action plan 2013–2020. Geneva: World Health Organization; 2013 (https://apps.who.int/iris/bitstream/handle/10665/89966/9789241506021_eng.pdf, accessed 31 August 2020).

Other

Global Health Observatory (GHO) Data [online database]. Mental health. In: World Health Organization [website] (https://apps.who.int/gho/data/node.main.MENTALHEALTH?lang=en, accessed 31 August 2020).

93. NUMBER OF PEOPLE WITH SUICIDE ATTEMPTS

COMMENT

Mental disorders contribute to 7% of the global burden of diseases and have significant impacts on health and major social, human rights and economic consequences in all countries of the world. Approximately half of all mental disorders start by age 14, and suicide is the second leading cause of death in young people aged 15–29.

Suicides and suicide attempts have a ripple effect that impacts families, friends, colleagues, communities and societies. Suicides are preventable.

WHO has published a mhGAP community toolkit (1) that can be used as a reference tool for the assessment of MNS disorders/mental health conditions by CHWs, including for exploring suicide attempts.

Confidentiality (see the mhGAP toolkit and section 7.5.4 in the main text of this guidance) and parental consent for adolescents according to national policy should be ensured.

CHW TASK

Identify and record people with suicide attempts.

CHW DATA POINTS TO COLLECT

Number of people who attempted suicide in the reporting period.

NUMERATOR

Number of people who reported attempting suicide in the reporting period.

DENOMINATOR

Number of people assessed in the reporting period.

DISAGGREGATION

Basic

- Gender (male, female, transgender)
- Pregnancy, postpartum
- Age (10–14, 15–19, 20+)
- Geographic area

Advanced

- Socioeconomic status (wealth quintile)
- Education level

MATURITY LEVEL

B.

FREQUENCY

Monthly.

DIGITALIZATION

Disaggregation can be automatic, especially for age, geographic area, sex, education level and socioeconomic status, if feasible.

ALIGNMENT

SDG *(2)*: The SDGs make specific reference to UHC of mental health under target 3.4 (By 2030, reduce by one third premature mortality from NCDs through prevention and treatment and promote mental health and well-being), including 3.4.2 on suicide prevention.

WHO 100 indicators: Includes suicide rate, but not suicide attempts or ideation *(3)*

Other

In 2013, the World Health Assembly implemented the WHO's comprehensive *Mental Health Action Plan 2013–2020 (4)*, which articulated pragmatic guidelines for the delivery of services, especially in LMICs. The action plan includes a target to reduce the rate of suicide in countries by 10% [by the year 2020]. The Seventy-second World Health Assembly (2019) extended the period of the action plan to 2030 in order to ensure their alignment with the 2030 Agenda for Sustainable Development.

REFERENCES

1. mhGAP community toolkit: field test version. Geneva: World Health Organization; 2019 (https://www.who.int/publications/i/item/the-mhgap-community-toolkit-field-test-version, accessed 31 August 2020).
2. Sustainable Development Goals. SDG indicators metadata repository. In: United Nations Statistics Division [website] (https://unstats.un.org/sdgs/metadata/, accessed 31 August 2020).
3. 2018 global reference list of 100 core health indicators (plus health-related SDGs). Geneva: WHO; 2018 (https://apps.who.int/iris/bitstream/handle/10665/259951/WHO-HIS-IER-GPM-2018.1-eng.pdf, accessed 31 August 2020).
4. Mental health action plan 2013–2020. Geneva: World Health Organization; 2013 (https://apps.who.int/iris/bitstream/handle/10665/89966/9789241506021_eng.pdf, accessed 31 August 2020).

Other

Global Health Observatory (GHO) Data [online database]. Mental health. In: World Health Organization [website] (https://apps.who.int/gho/data/node.main.MENTALHEALTH?lang=en, accessed 31 August 2020).

94. AVERAGE TIME ON WEEKDAYS AND WEEKEND DAYS DEDICATED TO SCREEN TIME FOR LEISURE ACTIVITIES

COMMENT

Average amount of time (hours, minutes) dedicated to screen time for leisure activities on weekdays and weekend days.

CHW TASK

- Ask a question on the average amount of time usually spent on a typical weekday playing video games, surfing the Internet, or watching TV for leisure activities.
- Ask a question on the average amount of time usually spent on a typical weekend day playing video games, surfing the Internet, or watching TV for leisure activities.

CHW DATA POINTS TO COLLECT

- The average amount of time (recorded in hours and minutes) the child/teenager/adult usually spends on a typical weekday playing video games, surfing the Internet, or watching TV for leisure activities.
- The average amount of time (recorded in hours and minutes) the child/teenager/adult usually spends on a typical weekend day playing video games, surfing the Internet, or watching TV for leisure activities.

NUMERATOR

- Total amount of time (recorded in hours and minutes) usually spent on a typical weekday playing video games, surfing the Internet, or watching TV for leisure activities by all children/teenagers/adults interviewed.
- Total amount of time (recorded in hours and minutes) usually spent on a typical weekend day playing video games, surfing the Internet, or watching TV for leisure activities by all children/teenagers/adults interviewed.

DENOMINATOR

- Number of children/teenagers/adults interviewed in the catchment area.

DISAGGREGATION

Basic

- Gender
- Age (<1, 1–2, 3–4, 5–12, 13–17, 18–24, 25–29, ≥30+)
- Geographic area
- Weekdays and weekend days

Advanced

- Socioeconomic status (wealth quintile)
- Education level

MATURITY LEVEL

B.

FREQUENCY

At least once a year.

DIGITALIZATION

Disaggregation can be automatic, especially for age, geographic area, sex, education level and socioeconomic status, if feasible.

ALIGNMENT

WHO NCD Global Monitoring Framework *(1)*

REFERENCES

1. Guidelines on physical activity, sedentary behaviour and sleep for children under 5 years of age. Geneva: World Health Organization; 2019 (https://www.who.int/publications/i/item/guidelines-on-physical-activity-sedentary-behaviour-and-sleep-for-children-under-5-years-of-age, accessed 31 August 2020).

95. NUMBER/PROPORTION OF PERSONS WHO ARE NOT UP TO DATE WITH IMMUNIZATIONS AND ARE REFERRED

COMMENT

The CHW can identify persons (infants, children, adolescents, women of childbearing age, pregnant women, other adults), who are not up to date with immunizations according to the national schedule.

Recommendations on immunization schedules can be found at: https://www.who.int/immunization/policy/immunization_tables/en/ *(1)*.

Once identified, the individuals can be referred to vaccination points to be brought up to date on their immunization schedule.

CHW TASK

Identification and referral of persons who are not up to date with immunizations according to national immunization schedule.

CHW DATA POINTS TO COLLECT

- Number of persons (infants, children, adolescents, women of childbearing age, pregnant women, other adults) who are not up to date with immunizations.
- Number of persons (infants, children, adolescents, women of childbearing age, pregnant women, other adults) who have been checked.

NUMERATOR

Number of persons (infants, children, adolescents, women of childbearing age, pregnant women, other adults) who are not up to date with immunizations and are referred.

DENOMINATOR

Number of persons (infants, children, adolescents, women of childbearing age, pregnant women, other adults) who have been checked.

DISAGGREGATION

Basic

- Geographic area
- Age
- Pregnant
- Sex (only where some vaccines target only females; for example, HPV, tetanus-containing)

Advanced

- Ethnic group
- Migratory status
- Main caregiver education level
- Socioeconomic status (wealth quintile)

MATURITY LEVEL

B.

FREQUENCY

Longitudinal follow-up is necessary.

DIGITALIZATION

Disaggregation can be automatic, especially for geographic area, age, pregnancy; and other advanced disaggregations such as sex and gender, ethnic group, migratory status, education level, belief and socioeconomic status, if feasible.

ALIGNMENT

SDG: 3.b.1: Proportion of the target population covered by all vaccines included in their national programme *(2)*

WHO 100 indicators: Immunization coverage rate by vaccine for each vaccine in the national schedule *(3)*

Global Strategy for Women's, Children's and Adolescents' Health: Diphtheria tetanus toxoid and pertussis (DTP3) immunization coverage among 1-year-olds (%) *(4)*

HDC facility guidance: Immunization coverage rate by vaccine for each vaccine in the national schedule *(5)*

REFERENCES

1. WHO recommendations for routine immunization – summary tables. Updated 8 September 2020. In: World Health Organization [website] (https://www.who.int/immunization/policy/immunization_tables/en/, accessed 31 August 2020).
2. Sustainable Development Goals. SDG indicators metadata repository. In: United Nations Statistics Division [website] (https://unstats.un.org/sdgs/metadata/, accessed 31 August 2020).
3. 2018 global reference list of 100 core health indicators (plus health-related SDGs). Geneva: WHO; 2018 (https://apps.who.int/iris/bitstream/handle/10665/259951/WHO-HIS-IER-GPM-2018.1-eng.pdf, accessed 31 August 2020).
4. Global Health Observatory (GHO) Data [online database]. Global Strategy for Women's, Children's and Adolescents' Health (2016–2030): Data portal. In: World Health Organization [website] (https://www.who.int/gho/publications/gswcah_portal/en/, accessed 31 August 2020).
5. Analysis and use of health facility data. In: World Health Organization [website] (https://www.who.int/healthinfo/tools_data_analysis_routine_facility/en/, accessed 31 August 2020).

96. NUMBER/PROPORTION OF CHILDREN UNDER 5 NEVER VACCINATED (ZERO-DOSE) AND REFERRED

COMMENT

This indicator is a subset of the number/proportion of persons who are not up to date with immunizations according to the national immunization schedule. It is important in terms of quality control, as the number should be lower compared to indicator 95 (number/proportion of persons who are not up to date with immunizations and are referred). This indicator is equally important to ensure that immunization services can reach marginalized communities in urban poor and remote rural settings so that no one is left behind, as is the goal of the Immunization Agenda 2030 (IA2030) endorsed by the World Health Assembly in August 2020 *(1)*.

For practicality, a child or adult is considered "zero-dose" if they never had vaccination (information from the parents in the case of a child), which is different from the global definition to monitor the IA2030 based on a proxy vaccine dose.

Once identified, they can be referred to vaccination points to be brought up to date on their immunization schedule. Recommendations on immunization schedules can be found at: https://www.who.int/immunization/policy/immunization_tables/en/ *(2)*.

The age groups will need to be adapted as per the vaccines recommended in the national routine immunization schedule. To embrace a life-course approach, countries may consider extending to additional age groups beyond 4 years of age; for example, children older than 5 years will still need to receive polio, measles, rubella, DTP, etc., if they were not vaccinated before.

CHW TASK

Identification and referral of children under 5 (or older) whose parents state they have never been vaccinated.

CHW DATA POINTS TO COLLECT

- Number of children under 5 (or older) whose parents state they have never been vaccinated, and who are referred.
- Number of children under 5 (or older) who have been checked.

NUMERATOR

Number of children under 5 (or older) whose parents state they have never been vaccinated, and who are referred.

DENOMINATOR

Number of children under 5 (or older) who have been checked.

DISAGGREGATION

Basic

- Geographic area
- Age groups: 0–11 months, 2–4 years; this disaggregation can be **extended** to other age groups following a life-course approach
- Sex (only where some vaccines target only females; for example, HPV, tetanus-containing)

Advanced

- Ethnic group
- Migratory status
- Main caregiver education level
- Socioeconomic status (wealth quintile)

MATURITY LEVEL

B.

Longitudinal follow-up is necessary.

FREQUENCY

Monthly or at least once a year.

DIGITALIZATION

Disaggregation can be automatic, especially for geographic area, age, pregnancy; and other advanced disaggregations such as sex and gender, ethnic group, migratory status, education level, belief and socioeconomic status, if feasible.

ALIGNMENT

None.

REFERENCES

1. Immunization Agenda 2030: A global strategy to leave no one behind. Geneva: World Health Organization; 2020 (https://www.who.int/immunization/immunization_agenda_2030/en/, accessed 31 August 2020).
2. WHO recommendations for routine immunization – summary tables. Updated 8 September 2020. In: World Health Organization [website] (https://www.who.int/immunization/policy/immunization_tables/en/, accessed 31 August 2020).

Other

2021–2025 Gavi Investment Opportunity. Geneva: GAVI, The Vaccine Alliance; 2019 (https://www.gavi.org/sites/default/files/publications/2021-2025%20Gavi%20Investment%20Opportunity.pdf, accessed 31 August 2020).

97. DETECTION AND REPORTING OF NEONATAL TETANUS

COMMENT

It is important to ensure that in places where there is community-based surveillance (CBS), CBS includes reporting from more than just CHWs (e.g. also from community leaders), and that there are not two parallel reporting streams. For example, a CHW should not report an alert to both their supervisor and a separate CBS Coordinator (e.g. International Committee of the Red Cross (ICRC)).

CHW TASK

Detection and referral for suspicion of neonatal tetanus (NT).

DENOMINATOR

None.

CHW DATA POINTS TO COLLECT

Number of neonates who had normal ability to suck and cry during the first 2 days of life and who cannot suck normally between 3 and 28 days of age or become stiff or have spasms (i.e. jerking of the muscles).

NUMERATOR

Number of neonates who had normal ability to suck and cry during the first 2 days of life and who cannot suck normally between 3 and 28 days of age or become stiff or have spasms (i.e. jerking of the muscles).

DISAGGREGATION

Basic

- Geographic area
- Confirmed as NT
- Dead/alive

Advanced

- None.

MATURITY LEVEL

A.

See WHO surveillance standards.

FREQUENCY

Besides immediate reporting and response, it can be useful for CHW supervisors/CBS programmes to measure the aggregate number of events or susceptible cases with a certain frequency, according to the nature of the event or cases (daily, weekly, or monthly), in order to monitor trends.

DIGITALIZATION

Data interoperability with services investigating NT is critical, whether from community health information system (CHIS) or health information system (HIS) (after referral).

Disaggregation can be automatic, especially for geographic area; age, if feasible to report.

ALIGNMENT

WHO Global Health Observatory: Neonatal tetanus – number of reported cases *(1)*

REFERENCES

1. Indicator Metadata Registry List: Number of reported cases of neonatal tetanus. In: WHO Global Health Observatory [website] (https://www.who.int/data/gho/indicator-metadata-registry/imr-details/58, accessed 31 August 2020).

Other

Surveillance standards for vaccine-preventable diseases. Geneva: World Health Organization; 2018 (https://www.who.int/immunization/monitoring_surveillance/burden/vpd/WHO_SurveillanceVaccinePreventable_00_FrontMatter_R2.pdf, accessed 31 August 2020).

98. DETECTION AND REPORTING OF ACUTE FLACCID PARALYSIS

COMMENT

It is important to ensure that in places where there is CBS, CBS includes reporting from more than just CHWs (e.g. also from community leaders), and that there are not two parallel reporting streams. For example, a CHW should not report an alert to both their supervisor and a separate CBS Coordinator (e.g. ICRC).

CHW TASK

Detection and referral for suspicion of acute flaccid paralysis.

DENOMINATOR

None.

CHW DATA POINTS TO COLLECT

Number of children under 15 years of age with suspicion of acute flaccid paralysis or any person of any age with paralytic illness if polio is suspected.

NUMERATOR

Number of children under 15 years of age with suspicion of acute flaccid paralysis or any person of any age with paralytic illness if polio is suspected.

DISAGGREGATION

Basic

- Geographic area
- Age
- Referred, non-referred

Advanced

- None.

MATURITY LEVEL

A.

See WHO surveillance standards.

FREQUENCY

Besides immediate reporting and response, it can be useful for CHW supervisors/CBS programmes to measure the aggregate number of events or susceptible cases with a certain frequency according to the nature of the event or cases (daily, weekly, or monthly), in order to monitor trends.

DIGITALIZATION

Data interoperability with services investigating acute flaccid paralysis is critical, whether from CHIS or HIS (after referral).

Disaggregation can be automatic, especially for geographic area; age, if feasible to report.

ALIGNMENT

WHO Global Health Observatory: Poliomyelitis – number of reported cases *(1)*

REFERENCES

1. Indicator Metadata Registry List: Number of reported cases of poliomyelitis/Number of reported cases of poliomyelitis by wild poliovirus (WPV). In: WHO Global Health Observatory [website] (https://www.who.int/data/gho/indicator-metadata-registry/imr-details/51, accessed 31 August 2020).

Other

Surveillance standards for vaccine-preventable diseases. Geneva: World Health Organization; 2018 (https://www.who.int/immunization/monitoring_surveillance/burden/vpd/WHO_SurveillanceVaccinePreventable_00_FrontMatter_R2.pdf, accessed 31 August 2020).

99. DETECTION AND REPORTING OF RASH AND FEVER FOR MEASLES OR MEASLES/RUBELLA

COMMENT

It is important to ensure that in places where there is CBS, CBS includes reporting from more than just CHWs (e.g. also from community leaders), and that there are not two parallel reporting streams. For example, a CHW should not report an alert to both their supervisor and a separate CBS Coordinator (e.g. ICRC).

CHW TASK

Detection and referral for rash and fever for measles or measles/rubella.

DENOMINATOR

None.

CHW DATA POINTS TO COLLECT

Number of persons with fever and maculopapular rash (i.e. nonvesicular) and cough, coryza (i.e. runny nose) or conjunctivitis (i.e. red eyes), or when a health worker suspects measles (or rubella), or the equivalent as per country definition.

NUMERATOR

Number of persons with fever and maculopapular rash (i.e. nonvesicular) and cough, coryza (i.e. runny nose) or conjunctivitis (i.e. red eyes), or when a health worker suspects measles (or rubella), or the equivalent as per country definition.

DISAGGREGATION

Basic

- Geographic area
- Age
- Referred, non-referred

Advanced

- None.

MATURITY LEVEL

A.

See WHO surveillance standards.

FREQUENCY

Besides immediate reporting and response, it can be useful for CHW supervisors/CBS programmes to measure the aggregate number of events or susceptible cases with a certain frequency according to the nature of the event or cases (daily, weekly, or monthly), in order to monitor trends.

DIGITALIZATION

Data interoperability with services investigating rash and fever is critical, whether from CHIS or HIS (after referral).

Disaggregation can be automatic, especially for geographic area; age, if feasible to report.

ALIGNMENT

WHO Global Health Observatory: Measles – number of reported cases *(1)*

REFERENCES

1. Indicator Metadata Registry List: Measles – number of reported cases. In: WHO Global Health Observatory [website] (https://www.who.int/data/gho/data/indicators/indicator-details/GHO/measles---number-of-reported-cases, accessed 31 August 2020).

Other

Surveillance standards for vaccine-preventable diseases. Geneva: World Health Organization; 2018 (https://www.who.int/immunization/monitoring_surveillance/burden/vpd/WHO_SurveillanceVaccinePreventable_00_FrontMatter_R2.pdf, accessed 31 August 2020).

100. POLIO VACCINATION WITH ORAL POLIO VACCINATION (OPV) (%)

COMMENT

The type of oral polio vaccination (OPV) used in routine immunization should be indicated clearly when reporting (as per the country immunization schedule). Schedules are available at: https://www.who.int/immunization/monitoring_surveillance/en (1) under Country Profiles.

CHW TASK

Polio vaccination (oral).

DENOMINATOR

Number of eligible children < 2 years in the target population.

CHW DATA POINTS TO COLLECT

- Number of eligible children < 2 years who received requested doses of polio vaccine (by dose number) according to national schedule.
- (Eligible children are children that should be vaccinated according to their age, the national schedule, and the absence of contraindication listed in the country materials.)

NUMERATOR

Number of eligible children < 2 years who received routine requested doses of polio vaccine (by dose number) according to national schedule.

DISAGGREGATION

Basic

- Number of doses (1, 2, 3+) according to nationally recommended dose schedule
- Geographic area
- Type of OPV (tOPV, bOPV, mOPV, nOPV)

Advanced

- None.

MATURITY LEVEL

B.

Longitudinal follow-up is necessary.

FREQUENCY

Monthly.

DIGITALIZATION

Unique identifier and longitudinal tracking – such as in an electronic immunization registry – could allow automatically pulling out of the number of children fully immunized.

Data interoperability with services conducting the same immunization would help to avoid double counting and wrong reporting of incomplete immunization.

Disaggregation can be automatic, especially for geographic area, age, number and type of doses, if feasible to report.

ALIGNMENT

WHO Global Health Observatory: Polio immunization coverage among one-year-olds (%) *(2)*

REFERENCES

1. Immunization, Vaccines and Biologicals. In: World Health Organization [website] (https://www.who.int/immunization/monitoring_surveillance/en/, accessed 31 August 2020).
2. Indicators: Polio immunization coverage among one-year-olds (%). In: Global Health Observatory [website] (https://www.who.int/data/gho/data/indicators/indicator-details/GHO/polio-immunization-coverage-among-one-year-olds-(-), accessed 31 August 2020).

Other

Electronic immunization registry: practical considerations for planning, development, implementation and evaluation. Washington (DC): PAHO; 2017 (http://iris.paho.org/xmlui/handle/123456789/34865, accessed 31 August 2020).

101. EARLY INFANT REFERRAL

COMMENT

Infants acquiring HIV during pregnancy, delivery or early postpartum often die before they are recognized as having HIV infection. WHO recommends that national programmes establish the capacity to provide early virological testing of infants for HIV at six weeks or as soon as possible thereafter to guide clinical decision-making at the earliest possible stage. HIV disease progresses rapidly among children; they need to start treatment as early as possible because, without early treatment, almost 50% of children would be dead by the second year.

CHW TASK

Referral of infants born to women living with HIV for virological test for HIV within two months of birth.

DENOMINATOR

Number of pregnant women living with HIV giving birth in the past 12 months in the catchment area.

CHW DATA POINTS TO COLLECT

Number of infants born to women living with HIV who were referred for an HIV test within two months of birth during the reporting period. Infants tested should only be counted once.

NUMERATOR

Number of infants who were referred for an HIV test within two months of birth. Infants tested should only be counted once.

DISAGGREGATION

Basic

- Age of infant in months
- Geographic area

Advanced

- HIV test of infant: positive, negative, indeterminate, or rejected for testing

MATURITY LEVEL

D.

Longitudinal follow-up is necessary, as well as interoperability of records between referral structures for HIV status and between the mother and the child.

FREQUENCY

Monthly.

ALIGNMENT

SDG: 3.3.1: Number of new HIV infections per 1000 uninfected population, by sex, age and key populations *(1)*

WHO 100 indicators: HIV incidence rate *(2)*

Global AIDS Monitoring 2020: Early infant diagnosis *(3)*

REFERENCES

1. Sustainable Development Goals. SDG indicators metadata repository. In: United Nations Statistics Division [website] (https://unstats.un.org/sdgs/metadata/, accessed 31 August 2020).
2. 2018 global reference list of 100 core health indicators (plus health-related SDGs). Geneva: WHO; 2018 (https://apps.who.int/iris/bitstream/handle/10665/259951/WHO-HIS-IER-GPM-2018.1-eng.pdf, accessed 31 August 2020).
3. Global AIDS Monitoring 2020: indicators for monitoring the 2016 Declaration on Ending AIDS. Geneva: UNAIDS; 2019 (https://www.unaids.org/sites/default/files/media_asset/global-aids-monitoring_en.pdf, accessed 31 August 2020).

102. NUMBER OF INDIVIDUAL HIV SELF-TESTING (HIVST) KITS DISTRIBUTED

COMMENT

Self-testing is an increasingly common mode of HIV testing that is not captured in other indicators of HIV testing service (HTS) coverage. Monitoring the implementation of this type of testing among target populations will help programme managers track progress and forecast the need for supportive services, such as linking clients to confirmatory testing and/or ART, as needed, as well as commodity supply chain needs. This indicator measures trends in the distribution of HIV self-testing (HIVST) kits at the community level.

Rapid HIV tests can be provided to CHWs with corresponding training and supervision. Journey from screening to referral, results feedback and eventual procedures should be clearly mapped, articulated, funded and integrated into the health system (including recommended frequency of screening).

The person-centred HIV patient monitoring and case surveillance guidelines discourage recording of key population status in patient monitoring tools (for example, registers and log books) used in general population facilities. Mechanisms can be adopted to ensure that key population status is linked to patient records only for data analysis. In the absence of this level of data security, disaggregating the priority indicators by key populations will be limited to facilities that offer services specifically for key populations.

CHW TASK

Distribution of HIVSV kits.

CHW DATA POINTS TO COLLECT

Number of individual HIVST kits distributed.

NUMERATOR

Number of individual HIVST kits distributed.

DENOMINATOR

None.

DISAGGREGATION

Basic

- Gender (male, female, transgender)
- Age (10–14, 15–19, 20–24, 25–29, 30–34, 35–39, 40–44, 45–49, 50+); age of consent to self-test varies by country context, which may require adaptation
- In all settings: key populations (men who have sex with men, people living in prisons and other closed settings, people who inject drugs, sex workers, transgender people) and other priority populations
- In high-burden settings, in addition to the above: adolescent girls and young women
- HIVST approach, as specified by national programme. For example, ANC contact, STI service, family planning service
- HIVST distribution by type of sites, as specified by national programme (for example, health post, door-to-door)
- Geographic area

Advanced

- None.

MATURITY LEVEL

A.

FREQUENCY

Quarterly/every three months or at least once a year.

ALIGNMENT

Global AIDS Monitoring 2020: HIV testing volume and positivity *(1)*

REFERENCES

1. Global AIDS Monitoring 2020: indicators for monitoring the 2016 Declaration on Ending AIDS. Geneva: UNAIDS; 2019 (https://www.unaids.org/sites/default/files/media_asset/global-aids-monitoring_en.pdf, accessed 31 August 2020).

Other

Consolidated HIV strategic information guidelines: driving impact through programme monitoring and management. Geneva: World Health Organization; 2020 (https://apps.who.int/iris/bitstream/handle/10665/331697/9789240000735-eng.pdf, accessed 31 August 2020).

103. NUMBER OF PEOPLE WHO WERE IDENTIFIED AND TESTED FOR HIV USING HIV INDEX TESTING SERVICES AND RECEIVED THEIR RESULTS

COMMENT

Contact testing, including among sexual partners, has been shown to increase the diagnosis of already-infected contacts and partners of newly identified HIV cases. Among serodiscordant couples, partner notification and testing can be a critical step in preventing infection of the uninfected partner. Contact and/or partner notification and testing should be voluntary and provided with supportive services. This indicator measures the coverage and impact of the index testing cascade of services for partners and other contacts (including children) of people living with HIV.

The person-centred HIV patient monitoring and case surveillance guidelines discourage recording of key population status in patient monitoring tools (for example, registers and log books) used in general population facilities. Mechanisms can be adopted to ensure that key population status is linked to patient records only for data analysis. In the absence of this level of data security, disaggregating the priority indicators by key populations will be limited to facilities that offer services specifically for key populations.

CHW TASK

HIV contact testing.

CHW DATA POINTS TO COLLECT

- Number of elicited partners of people diagnosed with HIV who received HTS.
- Additional cascade data collected:
  - Number of people diagnosed with HIV (index cases) offered partner services.
  - Number of people diagnosed with HIV (index cases) accepting partner services.
  - Number of contacts/partners of people living with HIV whose information is elicited from people diagnosed with HIV (index cases).

NUMERATOR

- Number of elicited partners of people diagnosed with HIV who received HTS.
- Additional cascade data collected:
  - Number of people diagnosed with HIV (index cases) offered partner services.
  - Number of people diagnosed with HIV (index cases) accepting partner services.
  - Number of contacts/partners of people living with HIV whose information is elicited from people diagnosed with HIV (index cases).

DISAGGREGATION

Basic

- By index case: gender (male, female, transgender)
- Age (0–4, 5–9, 10–14, 15–19, 20–24, 25–49, 50+)
- HIV status of partner or contact (already knew positive, newly diagnosed positive, negative)
- Key populations (men who have sex with men, people living in prisons and other closed settings, people who inject drugs, sex workers, transgender people)
- Geographic area

Advanced

- None.

MATURITY LEVEL

D.

FREQUENCY

Monthly or at least once a year.

ALIGNMENT

Consolidated HIV strategic information guidelines: Driving impact through programme monitoring and management *(1)*

REFERENCES

1. Consolidated HIV strategic information guidelines: driving impact through programme monitoring and management. Geneva: World Health Organization; 2020 (https://apps.who.int/iris/bitstream/handle/10665/331697/9789240000735-eng.pdf, accessed 31 August 2020).

104. PROPORTION OF PEOPLE ON PRE-EXPOSURE PROPHYLAXIS (PrEP) SUPPORTED AND COUNSELLED BY CHWs

COMMENT

The use of antiretroviral medicines by people who are HIV-negative before they are exposed to HIV can prevent HIV infection. WHO recommends that oral pre-exposure prophylaxis (PrEP) containing tenofovir be offered as an additional prevention choice for people at substantial risk of HIV infection as part of combination HIV prevention approaches.

CHW TASK

PrEP support and counselling.

CHW DATA POINTS TO COLLECT

Number of people who received oral PrEP at least once during the reporting period by CHW.

NUMERATOR

Number of people who received oral PrEP at least once during the reporting period who were supported and counselled by CHW.

DENOMINATOR

Number of people who received oral PrEP at least once during the reporting period.

DISAGGREGATION

Basic

- Gender (male, female, transgender)
- Age (15–19, 20–24, 25–49, 50+)
- Experience with PrEP (first-time users, repeat users)
- Key populations (men who have sex with men, people living in prisons and other closed settings, people who inject drugs, sex workers, transgender people) and adolescent girls and young women
- Geographic area

Advanced

- Socioeconomic status (wealth quintile)
- Education level

MATURITY LEVEL

B.

Longitudinal follow-up is necessary.

FREQUENCY

Monthly.

ALIGNMENT

Global AIDS Monitoring 2020: HIV testing volume and positivity *(1)*

REFERENCES

1. Global AIDS Monitoring 2020: indicators for monitoring the 2016 Declaration on Ending AIDS. Geneva: UNAIDS; 2019 (https://www.unaids.org/sites/default/files/media_asset/global-aids-monitoring_en.pdf, accessed 31 August 2020).

Other

Consolidated HIV strategic information guidelines: driving impact through programme monitoring and management. Geneva: World Health Organization; 2020 (https://apps.who.int/iris/bitstream/handle/10665/331697/9789240000735-eng.pdf, accessed 31 August 2020).

105. NUMBER AND PERCENTAGE OF PEOPLE LIVING WITH HIV REPORTED ON ANTIRETROVIRAL THERAPY (ART) AT THE END OF THE LAST REPORTING PERIOD AND/OR NEWLY INITIATING ART DURING THE CURRENT REPORTING PERIOD WHO WERE NOT ON ART AT THE END OF THE REPORTING PERIOD

COMMENT

This indicator measures progress towards promoting retention on antiretroviral therapy (ART) and mitigating loss – that is, ART attrition.

CHWs are instrumental for promoting, supporting and tracing ART treatment.

WHO currently recommends treatment for all people living with HIV to achieve viral suppression. ART retention analyses by category are essential to achieving this goal. This indicator is central to understanding total attrition (loss) from ART during a reporting period and to understanding net progress towards reaching the second 90/95 target.

The person-centred HIV patient monitoring and case surveillance guidelines discourage recording of key population status in patient monitoring tools (for example, registers and log books) used in general population facilities. Mechanisms can be adopted to ensure that key population status is linked to patient records only for data analysis. In the absence of this level of data security, disaggregating the priority indicators by key populations will be limited to facilities that offer services specifically for key populations.

CHW TASK

Promoting, supporting and tracing ART treatment.

DENOMINATOR

Number of people reported on ART at the end of the last reporting period plus new on ART during the current reporting period.

CHW DATA POINTS TO COLLECT

Identification of people living with HIV who are not on treatment at the end of the current reporting period (including those who died, stopped treatment and were lost to follow-up).

NUMERATOR

Number of people living with HIV reported on ART at the end of the last reporting period who were not on treatment at the end of the current reporting period (including those who died, stopped treatment and were lost to follow-up).

Plus

Number of people living with HIV newly initiated on ART during the current reporting period who were not on treatment at the end of the current reporting period (including those who died, stopped treatment or were lost to follow-up).

DISAGGREGATION

Basic

- Gender (male, female, transgender)
- Age (0–4, 5–9, 10–14, 15–19, 20–24, 25–29, 30–34, 35–39, 40–44, 45–49, 50+)
- Key populations (men who have sex with men, people living in prisons and other closed settings, people who inject drugs, sex workers, transgender people)
- Geographic area

Advanced

- Socioeconomic status (wealth quintile)
- Education level

MATURITY LEVEL

C.

Longitudinal follow-up is necessary, as well as information from referral structure on initiation of ART

FREQUENCY

The recommended maximum reporting period is 12 months. Shorter reporting intervals (e.g. three months) are recommended where feasible.

ALIGNMENT

Global AIDS Monitoring 2020: HIV testing volume and positivity *(1)*

REFERENCES

1. Global AIDS Monitoring 2020: indicators for monitoring the 2016 Declaration on Ending AIDS. Geneva: UNAIDS; 2019 (https://www.unaids.org/sites/default/files/media_asset/global-aids-monitoring_en.pdf, accessed 31 August 2020).

Other

Consolidated HIV strategic information guidelines: driving impact through programme monitoring and management. Geneva: World Health Organization; 2020 (https://apps.who.int/iris/bitstream/handle/10665/331697/9789240000735-eng.pdf, accessed 31 August 2020).

106. NUMBER OF PEOPLE LIVING WITH HIV ON ART

COMMENT

WHO currently recommends treatment for all people living with HIV to achieve viral suppression. This indicator is central to accountability for national health sector strategic plans, effective programme management and donor programming. This indicator is essential to measurement of the second 90/95 target: that 90% of the people who know their HIV-positive status are accessing ART by 2020 and 95% by 2025. This indicator measures progress towards providing ART to all people living with HIV, taking into account total attrition during the reporting period.

CHW TASK

ART follow-up or delivery.

DENOMINATOR

Number of people living with HIV who know their HIV status in the catchment area.

CHW DATA POINTS TO COLLECT

- Number of people on ART at the end of the reporting period.
- Number of people living with HIV who know their HIV status in the catchment area.

NUMERATOR

Number of people on ART at the end of the reporting period.

DISAGGREGATION

Basic

- Gender (male, female, transgender)
- Age (0–4, 5–9, 10–14, 15–19, 20–24, 25–29, 30–34, 35–39, 40–44, 45–49, 50+)
- Key populations (men who have sex with men, people living in prisons and other closed settings, people who inject drugs, sex workers, transgender people)
- Geographic area

Advanced

- Newly initiating ART during the current year
- Reinitiating ART after previously having stopped treatment or being classified as lost to follow-up (not seen within 28 days of the last expected clinical contact)
- Socioeconomic status (wealth)

MATURITY LEVEL

C.

Longitudinal follow-up is necessary, as well as interoperability of records between referral structures for HIV status.

FREQUENCY

Monthly.

ALIGNMENT

Global AIDS Monitoring 2020: driving impact through programme monitoring and management *(1)*

REFERENCES

1. Global AIDS Monitoring 2020: indicators for monitoring the 2016 Declaration on Ending AIDS. Geneva: UNAIDS; 2019 (https://www.unaids.org/sites/default/files/media_asset/global-aids-monitoring_en.pdf, accessed 31 August 2020).

Other

Consolidated HIV strategic information guidelines: driving impact through programme monitoring and management. Geneva: World Health Organization; 2020 (https://apps.who.int/iris/bitstream/handle/10665/331697/9789240000735-eng.pdf, accessed 31 August 2020).

90-90-90: an ambitious treatment target to help end the AIDS epidemic. Geneva: Joint United Nations Programme on HIV/AIDS; 2014 (https://www.unaids.org/sites/default/files/media_asset/90-90-90_en.pdf, accessed 31 August 2020).

107. AVOIDANCE OF HEALTH CARE DUE TO STIGMA AND DISCRIMINATION (KEY POPULATIONS)

COMMENT

Health-care settings are one of the most common places where members of key populations experience discrimination. Tracking the proportion of key populations that avoid health care due to stigma and discrimination provides managers with information about where to focus efforts to reduce discrimination and perceived discrimination by service providers, as well as identifying areas where service utilization by members of key populations can be improved.

This is a survey-based indicator drawn from the PLHIV Stigma Index (https://www.stigmaindex.org/) *(1)*. This indicator should be implemented within a country context considering the PLHIV Stigma Index survey, and the information should be analysed and reviewed with the programme indicator data to inform programme improvements. Obviously, CHWs may also be sources of stigma and discrimination, akin to other health workforce cadres, but people can also report them and stigma and discrimination they face in other health-care settings.

The person-centred HIV patient monitoring and case surveillance guidelines discourage recording of key population status in patient monitoring tools (for example, registers and log books) used in general population facilities. Mechanisms can be adopted to ensure that key population status is linked to patient records only for data analysis. In the absence of this level of data security, disaggregating the priority indicators by key populations will be limited to facilities that offer services specifically for key populations.

Confidentiality is critical (see section 7.5.4 in the main text of this guidance).

CHW TASK

Review of health-care avoidance due to stigma and discrimination for key populations.

DENOMINATOR

Number of respondents.

CHW DATA POINTS TO COLLECT

Number of respondents who stated they have ever avoided seeking any health care, or HIV testing or HIV medical care or HIV treatment in the last 12 months due to fear of or concern about stigma or that someone may learn they belong to a key population, or about experience of violence, or about experiencing harassment or arrest by police.

NUMERATOR

Number of respondents who stated they have ever avoided seeking any health care, or HIV testing or HIV medical care or HIV treatment in the last 12 months due to fear of or concern about stigma or that someone may learn they belong to a key population, or about experience of violence, or about experiencing harassment or arrest by police.

DISAGGREGATION

Basic

- Age (10–14, 15–19, 20–24, 25+)
- Key populations (men who have sex with men, people who inject drugs, sex workers, transgender people)
- Geographic area

Advanced

- None.

MATURITY LEVEL

C.

FREQUENCY

Once a year.

ALIGNMENT

Consolidated HIV strategic information guidelines: Driving impact through programme monitoring and management *(2)*

REFERENCES

1. PLHIV Stigma Index. In: Global Network of People Living with HIV (GNP+) [website] (https://www.stigmaindex.org/, accessed 31 August 2020).
2. Consolidated HIV strategic information guidelines: driving impact through programme monitoring and management. Geneva: World Health Organization; 2020 (https://apps.who.int/iris/bitstream/handle/10665/331697/9789240000735-eng.pdf, accessed 31 August 2020).

108. AVOIDANCE OF HEALTH CARE DUE TO STIGMA AND DISCRIMINATION (PEOPLE LIVING WITH HIV)

COMMENT

Health-care settings are one of the most common places where people living with HIV and those perceived to be living with HIV experience discrimination. Tracking the proportion of people living with HIV who avoid health care due to stigma and discrimination provides managers with information about where to focus efforts to reduce discrimination and perceived discrimination by service providers, as well as identifying areas where service utilization by people living with HIV can be improved.

This is a survey-based indicator drawn from the PLHIV Stigma Index (https://www.stigmaindex.org/) *(1)*.This indicator should be implemented within a country context considering the PLHIV Stigma Index survey, and the information should be analysed and reviewed with the programme indicator data to inform programme improvements. Obviously, CHWs may also be sources of stigma and discrimination, akin to other health workforce cadres, but people can also report them and stigma and discrimination they face in other health-care settings.

Confidentiality is critical (see section 7.5.4 in the main text of this guidance).

CHW TASK

Review of health-care avoidance due to sigma and discrimination for PLHIV.

DENOMINATOR

Number of respondents.

CHW DATA POINTS TO COLLECT

Number of respondents who stated they have ever avoided seeking any health care, or HIV testing or HIV medical care or HIV treatment in the last 12 months due to fear of or concern about stigma, that they are HIV-positive, or about or experience of violence.

NUMERATOR

Number of respondents who stated they have ever avoided seeking any health care, or HIV testing or HIV medical care or HIV treatment in the last 12 months due to fear of or concern about stigma, that they are HIV-positive, or about or experience of violence.

DISAGGREGATION

Basic

- Age (10–14, 15–19, 20–24, 25+)
- Geographic area

Advanced

- None.

MATURITY LEVEL

C.

FREQUENCY

Once a year.

ALIGNMENT

Consolidated HIV strategic information guidelines: Driving impact through programme monitoring and management *(2)*

REFERENCES

1. PLHIV Stigma Index. In: Global Network of People Living with HIV (GNP+) [website] (https://www.stigmaindex.org/, accessed 31 August 2020).
2. Consolidated HIV strategic information guidelines: driving impact through programme monitoring and management. Geneva: World Health Organization; 2020 (https://apps.who.int/iris/bitstream/handle/10665/331697/9789240000735-eng.pdf, accessed 31 August 2020).

109. PROPORTION OF PEOPLE ELIGIBLE FOR ANY FORM OF ECONOMIC SUPPORT REFERRED BY A CHW TO APPLY FOR IT

COMMENT

The indicator should not be specific to the type of economic support; for example, financial/transport support. The type of economic support should be country specific and in accordance with the national social protection guidelines (the same then obviously applies to all indicators). For instance, economic support is a critical social protection component of TB *patient-centred care* and, *depending on needs*, all TB patients should receive economic (livelihood) support to enable them to complete the diagnostic process and full course of required treatment.

Countries should develop standard eligibility criteria for inclusion, including poor patients, patients with M(X) DR TB and migrants.

Ideally, presumptive TB patients would also require economic support in the form of transport for the initial diagnostic process, in order to ensure outreach community-led diagnostic services and community sputum collection.

CHW TASK

Referring eligible patients to available economic support programmes.

CHW DATA POINTS TO COLLECT

Number of eligible people referred for economic (livelihood) support by a CHW.

NUMERATOR

Number of eligible people referred for economic (livelihood) support by a CHW.

DENOMINATOR

Total number of eligible people in the catchment area.

DISAGGREGATION

Basic

- Eligible condition (TB, HIV, NTD, etc.)
- Gender (male, female, transgender)
- Geographic area
- Type of support (financial, transport, etc.)
- Sex (male, female, other)

Advanced

- TB key population (PLHIV, people who use drugs, miners, prisoners, health workers, indigenous persons, mobile and migrant populations, urban poor)

MATURITY LEVEL

B.

Longitudinal follow-up is key.

FREQUENCY

Monthly.

DIGITALIZATION

Disaggregation can be automatic, especially if there is interoperability with HIV/TB status, for age, gender, geographic area, if feasible.

ALIGNMENT

None.

REFERENCES

None.

110. PROPORTION OF PEOPLE ELIGIBLE FOR ANY FORM OF ECONOMIC SUPPORT THAT RECEIVE(D) IT

COMMENT

The indicator should not be specific to the type of economic support; for example, financial/transport support. The type of economic support should be country specific and in accordance with the national social protection guidelines (the same then obviously applies to all indicators). For instance, economic support is a critical social protection component of TB *patient-centred care* and, *depending on needs*, all TB patients should receive economic (livelihood) support to enable them to complete the diagnostic process and full course of required treatment.

Countries should develop standard eligibility criteria for inclusion, including poor patients, patients with M(X) DR TB and migrants. Ideally, presumptive TB patients would also require economic support in the form of transport for the initial diagnostic process, in order to ensure outreach community-led diagnostic services and community sputum collection.

CHW TASK

Review whether eligible people received available economic support programmes and refer if needed.

CHW DATA POINTS TO COLLECT

Number of eligible people that receive(d) any form of economic support.

NUMERATOR

Number of eligible people that receive(d) any form of economic support.

DENOMINATOR

Total number of eligible people.

DISAGGREGATION

Basic

- Eligible condition (TB, HIV, NTD, etc.)
- Age
- Gender (male, female, transgender)
- Geographic area
- Type of support (financial, transport, etc.)
- Sex (male, female, other)

Advanced

- TB key population (people who use drugs, miners, prisoners, health workers, indigenous persons, mobile and migrant populations, urban poor)
- HIV key populations (men who have sex with men, people who inject drugs, sex workers, transgender people)

MATURITY LEVEL

B.

Longitudinal follow-up is key.

FREQUENCY

Monthly or at least once a year.

DIGITALIZATION

Disaggregation can be automatic, especially if there is interoperability with HIV/TB status, for age, gender, geographic area, if feasible.

ALIGNMENT

None.

REFERENCES

None.

111. PROPORTION OF ELIGIBLE PEOPLE FOR LEGAL SERVICES REFERRED BY A CHW TO APPLY FOR THEM

COMMENT

Affected community members often face serious human rights and legal barriers along the continuum of care; for instance, when affected by TB. They may need support from legal services and their testimonies are essential in informing the judicial, legal, medical, human rights and public health communities.

CHW TASK

Refer eligible people for legal services.

CHW DATA POINTS TO COLLECT

Number of eligible people referred for legal services by a CHW.

NUMERATOR

Number of eligible people referred for legal services by a CHW.

DENOMINATOR

Total number of people eligible for legal services in the catchment area.

DISAGGREGATION

Basic

- Eligible condition (TB, HIV, NTD, etc.)
- Age
- Gender (male, female, transgender)
- Geographic area
- Type of support (financial, transport, etc.)
- Sex (male, female, other)

Advanced

- TB key population (PLHIV, people who use drugs, miners, prisoners, health workers, indigenous persons, mobile and migrant populations, urban poor)
- HIV key populations (men who have sex with men, people who inject drugs, sex workers, transgender people)

MATURITY LEVEL

B.

Longitudinal follow-up is key.

FREQUENCY

Monthly.

DIGITALIZATION

Disaggregation can be automatic, especially if there is interoperability with HIV/TB status, for age, gender, geographic area, if feasible.

ALIGNMENT

None.

REFERENCES

1. StopTB Partnership. TB, Human Rights and the Law Task Force. 11 October 2016. In: Global Drug-resistant TB Initiative (GDI) [website] (http://www.stoptb.org/wg/mdrtb/taskforces.asp?tf=5, accessed 31 August 2020).
2. International Human Rights Clinic, University of Chicago Law School. Tuberculosis, human rights and the law: a compendium of case law. First edition. Chicago: University of Chicago Law School; 2017 (http://www.stoptb.org/assets/documents/communities/TB%20Human%20Rights%20and%20the%20Law%20Case%20Compendium%20(First%20Edition).pdf, accessed 31 August 2020).

112. PROPORTION OF ELIGIBLE PEOPLE THAT RECEIVE(D) LEGAL SERVICES

COMMENT

Affected community members often face serious human rights and legal barriers along the continuum of care; for instance, when affected by TB. They may need support from legal services and their testimonies are essential in informing the judicial, legal, medical, human rights and public health communities.

CHW TASK

Review whether eligible people received legal services and refer if needed.

CHW DATA POINTS TO COLLECT

Number of eligible people that receive(d) any form of legal services.

NUMERATOR

Number of eligible people that receive(d) any form of legal services.

DENOMINATOR

Total number of eligible people.

DISAGGREGATION

Basic

- Eligible condition (TB, HIV, NTD, etc.)
- Age
- Gender (male, female, transgender)
- Geographic area
- Type of legal services
- Sex (male, female, other)

Advanced

- TB key population (people who use drugs, miners, prisoners, health workers, indigenous persons, mobile and migrant populations, urban poor)
- HIV key populations (men who have sex with men, people who inject drugs, sex workers, transgender people)

MATURITY LEVEL

B.

Longitudinal follow-up is key.

FREQUENCY

Monthly or at least once a year.

DIGITALIZATION

Disaggregation can be automatic, especially if there is interoperability with HIV/TB status, for age, gender, geographic area, if feasible.

ALIGNMENT

None.

REFERENCES

None.

113. NUMBER/PROPORTION OF CHILDREN UNDER 5 WHO HAD FEVER IN THE LAST TWO WEEKS

COMMENT

Ideally, this question would be asked at a household assessment taking place during malaria transmission season. In any case, the date (day and month) the question is asked should be recorded.

CHW TASK

Identify number of children under 5 who had fever in the last two weeks.

CHW DATA POINTS TO COLLECT

- Number of children under 5 who had fever in the last two weeks.
- Number of children under 5 in the catchment area.

NUMERATOR

Number of children under 5 who had fever in the last two weeks.

DENOMINATOR

Number of children under 5 in the catchment area.

DISAGGREGATION

Basic

- Age (0–11 months, 1–4 years)
- Geographic area
- Date (day and month) the question was asked

Advanced

- Sex (male, female)

MATURITY LEVEL

B.

FREQUENCY

At least once a year.

DIGITALIZATION

Disaggregation can be automatic for age, geographic area, time, sex, if the information is already collected with individual identifier.

ALIGNMENT

None.

REFERENCES

None.

114. NUMBER/PROPORTION OF HOUSEHOLDS WITH AT LEAST ONE INSECTICIDE-TREATED NETS (ITN)

COMMENT

This indicator is useful to measure the reach of insecticide-treated net (ITN) distributions, and when used with the indicator on households with at least one ITN for every two people, calculate the intra-household ITN gap.

CHW TASK

Identification of households with at least one ITN.

CHW DATA POINTS TO COLLECT

- Number of ITNs usable in the household.
- Number of households.

NUMERATOR

Number of households with at least one ITN.

DENOMINATOR

Total number of households.

DISAGGREGATION

Basic

- Geographic area

Advanced

- Socioeconomic status
- Higher education status in the household
- Size of household
- Ethnic group
- Migratory status

MATURITY LEVEL

B.

Longitudinal follow-up is important to avoid double counting.

FREQUENCY

At least once a year.

DIGITALIZATION

Numerator and percentage could be automatically calculated.

Disaggregation can be automatic for geographic area, socioeconomic status, education status, ethnic group, size, if the information is also collected in the household.

ALIGNMENT

Malaria surveillance, monitoring and evaluation: a reference manual: Proportion of households with at least one ITN *(1)*

REFERENCES

1. Malaria surveillance, monitoring and evaluation: a reference manual. Geneva: World Health Organization; 2018 (https://apps.who.int/iris/bitstream/handle/10665/272284/9789241565578-eng.pdf, accessed 31 August 2020).

115. NUMBER/PROPORTION OF HOUSEHOLDS WITH AT LEAST ONE ITN FOR EVERY TWO PERSONS

COMMENT

This indicator may be difficult to collect in a paper-based system, as there should be some calculation for each household. This indicator may be more feasible in a well-designed digital-based system.

CHW TASK

Identification of households with at least one ITN for every two persons.

CHW DATA POINTS TO COLLECT

- Number of ITNs usable in the household.
- Number of individuals who live in the household.

NUMERATOR

Number of households with at least one ITN for every two persons.

DENOMINATOR

Total number of individuals who live in the household.

DISAGGREGATION

Basic

- Geographic area

Advanced

- Socioeconomic status
- Higher education status in the household
- Size of household
- Ethnic group
- Migratory status

MATURITY LEVEL

B.

Longitudinal follow-up is important to avoid double counting.

FREQUENCY

At least once a year.

DIGITALIZATION

Numerator and percentage could be automatically calculated.

Disaggregation can be automatic for geographic area, socioeconomic status, education status, ethnic group, size, if the information is also collected in the household.

ALIGNMENT

Malaria surveillance, monitoring and evaluation: a reference manual: Proportion of population with access to an ITN in their household *(1)*

REFERENCES

1. Malaria surveillance, monitoring and evaluation: a reference manual. Geneva: World Health Organization; 2018 (https://apps.who.int/iris/bitstream/handle/10665/272284/9789241565578-eng.pdf, accessed 31 August 2020).

116. NUMBER/PROPORTION OF POPULATION WHO SLEPT UNDER AN ITN THE PREVIOUS NIGHT

CHW TASK

Identification of individuals using an ITN.

CHW DATA POINTS TO COLLECT

- Number of individuals stating they slept under an ITN the previous night.
- Number of individuals in the households visited.

NUMERATOR

Number of individuals stating they slept under an ITN the previous night.

DENOMINATOR

Number of individuals in the households visited.

DISAGGREGATION

Basic

- Geographic area
- Individuals living in a house sprayed by indoor residual spraying (IRS) in the previous 12 months: Yes/No

Advanced

- Socioeconomic status
- Higher education status in the household
- Size of household
- Ethnic group
- Migratory status

MATURITY LEVEL

B.

Longitudinal follow-up is important to avoid double counting.

FREQUENCY

At least once a year.

DIGITALIZATION

Numerator and percentage could be automatically calculated.

Disaggregation can be automatic for geographic area, socioeconomic status, education status, ethnic group, size, if the information is also collected in the household.

ALIGNMENT

WHO 100 indicators: Use of insecticide treated nets (ITNs) *(1)*

Global Strategy for Women's, Children's and Adolescents' Health: Children aged <5 years sleeping under insecticide-treated nets *(2)*

Malaria surveillance, monitoring and evaluation: a reference manual: Proportion of population at risk sleeping under an ITN or living in a house sprayed by IRS in the previous 12 months *(3)*

REFERENCES

1. 2018 global reference list of 100 core health indicators (plus health-related SDGs). Geneva: WHO; 2018 (https://apps.who.int/iris/bitstream/handle/10665/259951/WHO-HIS-IER-GPM-2018.1-eng.pdf, accessed 31 August 2020).
2. Global Health Observatory (GHO) Data [online database]. Global Strategy for Women's, Children's and Adolescents' Health (2016–2030): Data portal. In: World Health Organization [website] (https://www.who.int/gho/publications/gswcah_portal/en/, accessed 31 August 2020).
3. Malaria surveillance, monitoring and evaluation: a reference manual. Geneva: World Health Organization; 2018 (https://apps.who.int/iris/bitstream/handle/10665/272284/9789241565578-eng.pdf, accessed 31 August 2020).

117. NUMBER/PROPORTION OF POPULATION LIVING IN A HOUSE SPRAYED BY IRS IN THE PREVIOUS 12 MONTHS

COMMENT

This indicator would only be useful in areas targeted for IRS, sometimes not for use at national level. In the updated reference manual from the Monitoring and Evaluation Reference Group (MERG) on household surveys, it is explained that this indicator is no longer recommended for national-level use due to the targeted nature of IRS.

CHW TASK

Identification of individuals using an ITN or living in a house sprayed by IRS in the previous 12 months.

CHW DATA POINTS TO COLLECT

- Number of individuals stating they live in a house sprayed by IRS in the previous 12 months.
- Number of individuals in the households visited.

NUMERATOR

Number of individuals stating they live in a house sprayed by IRS in the previous 12 months.

DENOMINATOR

Number of individuals in the households visited.

DISAGGREGATION

Basic

- Geographic area

Advanced

- Socioeconomic status
- Higher education status in the household
- Size of household
- Ethnic group
- Migratory status

MATURITY LEVEL

B.

Longitudinal follow-up is important to avoid double counting.

FREQUENCY

At least once a year.

DIGITALIZATION

Numerator and percentage could be automatically calculated.

Disaggregation can be automatic for geographic area, socioeconomic status, education status, ethnic group, size, if the information is also collected in the household.

ALIGNMENT

WHO 100 indicators: Indoor residual spraying (IRS) coverage *(1)*

Malaria surveillance, monitoring and evaluation: a reference manual: Proportion of population at risk sleeping under an ITN or living in a house sprayed by IRS in the previous 12 months *(2)*

REFERENCES

1. 2018 global reference list of 100 core health indicators (plus health-related SDGs). Geneva: WHO; 2018 (https://apps.who.int/iris/bitstream/handle/10665/259951/WHO-HIS-IER-GPM-2018.1-eng.pdf, accessed 31 August 2020).
2. Malaria surveillance, monitoring and evaluation: a reference manual. Geneva: World Health Organization; 2018 (https://apps.who.int/iris/bitstream/handle/10665/272284/9789241565578-eng.pdf, accessed 31 August 2020).

118. NUMBER OF ITNs DISTRIBUTED BY CHWs

COMMENT

This indicator should be carefully interpreted. It informs on the availability of ITNs but not on its use.

CHW TASK

Distribution of ITNs.

CHW DATA POINTS TO COLLECT

Number of ITNs distributed.

NUMERATOR

Number of ITNs distributed.

DENOMINATOR

None.

DISAGGREGATION

Basic

- Geographic area

Advanced

- Population at risk (infants, children under 5, pregnant women, people living with HIV/AIDS, non-immune migrants, mobile populations, travelers)

MATURITY LEVEL

A.

FREQUENCY

Monthly or at least once a year.

DIGITALIZATION

Disaggregation can be automatic for the population at risk if the information is already collected with individual identifier.

ALIGNMENT

HDC facility guidance: Malaria: Facility distribution of mosquito nets *(1)*

REFERENCES

1. Analysis and use of health facility data. Guidance for malaria programme managers. Working Document. September 2018. Geneva: World Health Organization; 2018 (https://www.who.int/healthinfo/FacilityAnalysisGuide_Malaria.pdf, accessed 31 August 2020).

119. NUMBER/PROPORTION OF FEBRILE CASES WHO RECEIVED A RAPID DIAGNOSTIC TEST (RDT)

COMMENT

Certain countries will report on febrile cases rather than suspected cases. Stock-outs of rapid diagnostic test (RDTs) may be a reason for a low numerator.

CHW TASK

Malaria test.

CHW DATA POINTS TO COLLECT

- Number of febrile cases who received a RDT.
- Number of febrile cases.

NUMERATOR

Number of febrile cases who received a RDT.

DENOMINATOR

Number of febrile cases of malaria.

DISAGGREGATION

Basic

- Age (0–4, 5–9, 10–14, 15–19, 20+)
- Geographic area
- Date of test

Advanced

- Malaria symptoms

MATURITY LEVEL

B.

Longitudinal follow-up is important if the test is repeated to not double count the same suspected case.

FREQUENCY

Monthly.

DIGITALIZATION

Disaggregation can be automatic for age, geographic area, time, sex, if the information is already collected with individual identifier.

A preset menu can also facilitate the collection of malaria symptoms.

ALIGNMENT

HDC facility guidance: Malaria: Number of confirmed outpatient diagnoses of malaria *(1)*

Malaria surveillance, monitoring and evaluation: a reference manual: Proportion of patients with suspected malaria who received a parasitological test *(2)*

REFERENCES

1. Analysis and use of health facility data. Guidance for malaria programme managers. Working Document. September 2018. Geneva: World Health Organization; 2018 (https://www.who.int/healthinfo/FacilityAnalysisGuide_Malaria.pdf, accessed 31 August 2020).
2. Malaria surveillance, monitoring and evaluation: a reference manual. Geneva: World Health Organization; 2018 (https://apps.who.int/iris/bitstream/handle/10665/272284/9789241565578-eng.pdf, accessed 31 August 2020).

120. NUMBER/PROPORTION OF SUSPECTED CASES WHO RECEIVED A RDT

COMMENT

Certain countries will report on suspected cases rather than febrile cases. Stock-outs of RDTs may be a reason for a low numerator.

CHW TASK

Malaria test.

CHW DATA POINTS TO COLLECT

- Number of suspected cases who received a RDT.
- Number of suspected cases.

NUMERATOR

Number of suspected cases who received a RDT.

DENOMINATOR

Number of suspected cases of malaria.

DISAGGREGATION

Basic

- Age (0–4, 5–9, 10–14, 15–19, 20+)
- Geographic area
- Date of test

Advanced

- Malaria symptoms

MATURITY LEVEL

B.

Longitudinal follow-up is important if the test is repeated to not double count the same suspected case.

FREQUENCY

Monthly.

DIGITALIZATION

Disaggregation can be automatic for age, geographic area, date, sex, if the information is already collected with individual identifier.

ALIGNMENT

HDC facility guidance: Malaria: Number of confirmed outpatient diagnoses of malaria *(1)*

Malaria surveillance, monitoring and evaluation: a reference manual: Proportion of patients with suspected malaria who received a parasitological test *(2)*

REFERENCES

1. Analysis and use of health facility data. Guidance for malaria programme managers. Working Document. September 2018. Geneva: World Health Organization; 2018 (https://www.who.int/healthinfo/FacilityAnalysisGuide_Malaria.pdf, accessed 31 August 2020).
2. Malaria surveillance, monitoring and evaluation: a reference manual. Geneva: World Health Organization; 2018 (https://apps.who.int/iris/bitstream/handle/10665/272284/9789241565578-eng.pdf, accessed 31 August 2020).

121. MALARIA RDT POSITIVITY RATE

CHW TASK
Malaria test.

CHW DATA POINTS TO COLLECT
- Number of confirmed malaria cases.
- Number of febrile cases who received a RDT.

NUMERATOR
Number of confirmed malaria cases.

DENOMINATOR
Number of febrile cases who received a RDT.

DISAGGREGATION

Basic
- Age (0–4, 5–9, 10–14, 15–19, 20+)
- Geographic area
- Date (month)
- Parasite species (can be combined): Plasmodium falciparum, Plasmodium knowlesi, Plasmodium malariae, Plasmodium ovale, Plasmodium vivax

Advanced
- Detection (passive, active)
- Time of malaria symptoms' onset (less than 24 or 48 hours, more than 48 hours)

MATURITY LEVEL
A.

FREQUENCY
Monthly.

DIGITALIZATION
Disaggregation can be automatic for age, geographic area, date, sex, if the information is already collected with individual identifier.

A preset menu can also facilitate the collection of parasite species and type of detection.

ALIGNMENT
HDC facility guidance: Malaria: Malaria test positivity rate (proportion of cases with symptoms diagnosed within 24 hours) *(1)*

Malaria surveillance, monitoring and evaluation: a reference manual: Malaria test positivity rate (proportion of detected cases that contacted health services within 48 hours of appearance of symptoms) *(2)*

REFERENCES

1. Analysis and use of health facility data. Guidance for malaria programme managers. Working Document. September 2018. Geneva: World Health Organization; 2018 (https://www.who.int/healthinfo/FacilityAnalysisGuide_Malaria.pdf, accessed 31 August 2020).
2. Malaria surveillance, monitoring and evaluation: a reference manual. Geneva: World Health Organization; 2018 (https://apps.who.int/iris/bitstream/handle/10665/272284/9789241565578-eng.pdf, accessed 31 August 2020).

122. NUMBER/PROPORTION OF PATIENTS WITH MALARIA WHO RECEIVED FIRST-LINE ANTIMALARIAL TREATMENT ACCORDING TO NATIONAL POLICY

COMMENT

The disaggregation by "patients suspected non-confirmed" or "febrile non-confirmed", versus confirmed with RDTs, is critical. Confirmation by RDT is clearly recommended, but in countries with repeated stock-outs of tests, this disaggregation allows inclusion of people treated without confirmation. Each country should then choose based on their CHW standard operating procedures whether CHWs should report either "suspected non-confirmed" or "febrile non-confirmed" cases.

CHW DATA POINTS TO COLLECT

- Number of patients with malaria who received first-line antimalarial treatment according to national policy.
- Number of patients with malaria.

NUMERATOR

Number of patients with malaria who received first-line antimalarial treatment according to national policy.

DENOMINATOR

Number of patients with malaria.

DISAGGREGATION

Basic

- Confirmed with RDT/suspected non-confirmed or febrile non-confirmed
- Age (0–4, 5–9, 10–14, 15–19, 20+)
- Geographic area
- Date treatment was received

Advanced

- Parasite species
- Detection (passive, active)
- Sex/gender

MATURITY LEVEL

A.

FREQUENCY

Monthly.

DIGITALIZATION

Disaggregation can be automatic for age, geographic area, date, sex, if the information is already collected with individual identifier.

A preset menu can also facilitate the collection of parasite species and type of detection.

ALIGNMENT

WHO 100 indicators: Treatment of confirmed malaria cases *(1)*

HDC facility guidance: Malaria: Malaria cases given artemisinin-based combination therapy (ACT) *(2)*

Malaria surveillance, monitoring and evaluation: a reference manual: Proportion of patients with confirmed malaria who received first-line antimalarial treatment according to national policy *(3)*

REFERENCES

1. 2018 global reference list of 100 core health indicators (plus health-related SDGs). Geneva: WHO; 2018 (https://apps.who.int/iris/bitstream/handle/10665/259951/WHO-HIS-IER-GPM-2018.1-eng.pdf, accessed 31 August 2020).
2. Analysis and use of health facility data. Guidance for malaria programme managers. Working Document. September 2018. Geneva: World Health Organization; 2018 (https://www.who.int/healthinfo/FacilityAnalysisGuide_Malaria.pdf, accessed 31 August 2020).
3. Malaria surveillance, monitoring and evaluation: a reference manual. Geneva: World Health Organization; 2018 (https://apps.who.int/iris/bitstream/handle/10665/272284/9789241565578-eng.pdf, accessed 31 August 2020).

123. NUMBER/PROPORTION OF CHILDREN WITH CONFIRMED MALARIA AND DANGER SIGNS WHO ARE REFERRED

COMMENT

This indicator is a subset of the indicator "Proportion of children referred for severe disease/danger signs". This is important to check for quality control.

The maturity score is C if the disaggregation includes completeness of referral. If not, it can be A. It is indeed very important to track whether the referral was completed and if it was timely, especially in malaria pre-elimination settings. This needs more case-based surveillance, and more mature CHIS systems.

CHW TASK

Confirmation of malaria with RDT, identification of danger signs and referral.

CHW DATA POINTS TO COLLECT

- Number of children with confirmed malaria and danger signs referred.
- Number of children with confirmed malaria and danger signs.

NUMERATOR

Number of children with confirmed malaria and danger signs referred.

DENOMINATOR

Number of children with confirmed malaria and danger signs.

DISAGGREGATION

Basic

- Age (0–11 months, 1–4 years, 5–9 years)
- Geographic area
- Date and time of referral

Advanced

- Completeness of referral
- Parasite species
- Detection (passive, active)
- Sex (male, female, intersex)
- Main caregiver's socioeconomic status
- Main caregiver's education status
- Ethnic group
- Migratory status

MATURITY LEVEL

A/C.

Interoperability with facility data is critical to know when referral has been completed.

FREQUENCY

Monthly.

DIGITALIZATION

Interoperability with facility data is critical to know when referral has been completed.

Disaggregation can be automatic for age, geographic area, time, sex, main caregiver's education level and socioeconomic status, ethnic group, if the information is already collected with individual identifier.

A preset menu can also facilitate the collection of parasite species and type of detection.

ALIGNMENT

None.

REFERENCES

None.

124. NUMBER/PROPORTION OF CHILDREN WITH MALARIA DANGER SIGNS REFERRED AFTER ADMINISTRATION OF RECTAL ARTESUNATE

COMMENT

This indicator should be considered when rectal artesunate can be administered by CHWs in the country. Stock-outs of RDTs may be a reason for a low numerator.

CHW TASK

Identification of danger signs and referral after administration of rectal artesunate.

CHW DATA POINTS TO COLLECT

- Number of children with malaria danger signs referred after administration of rectal artesunate.
- Number of children with malaria danger signs.

NUMERATOR

Number of children with malaria danger signs referred after administration of rectal artesunate.

DENOMINATOR

Number of children with malaria danger signs.

DISAGGREGATION

Basic

- Age (0–11 months, 1–4 years, 5–9 years)
- Geographic area
- Date and time of referral

Advanced

- Completeness of referral
- Parasite species
- Detection (passive, active)
- Sex (male, female, intersex)
- Main caregiver's socioeconomic status
- Main caregiver's education status
- HIV status of mother and child
- Ethnic group
- Migratory status

MATURITY LEVEL

A/C.

Interoperability with facility data is critical to know when referral has been completed.

FREQUENCY

Monthly.

DIGITALIZATION

Interoperability with facility data is critical to know when referral has been completed.

Disaggregation can be automatic for age, geographic area, date, sex, main caregiver's level education level and socioeconomic status, ethnic group, if the information is already collected with individual identifier.

A preset menu can also facilitate the collection of parasite species and type of detection.

ALIGNMENT

None.

REFERENCES

None.

125. NUMBER OF PREGNANT WOMEN WHO HAVE RECEIVED ZERO/ONE/TWO/THREE OR MORE DOSES OF INTERMITTENT PREVENTIVE TREATMENT OF MALARIA IN PREGNANCY (IPTp)

COMMENT

Disaggregation is critical to evaluate efficiency and progress of any intervention for pregnant women to complete intermittent preventive treatment of malaria in pregnancy (IPTp) according to national policy.

WHO suggests that CHWs be considered for providing this supplementation in the context of targeted monitoring and evaluation.

This indicator can be problematic in terms of data quality, especially if IPTp is delivered in different settings.

CHW TASK

IPTp delivery.

CHW DATA POINTS TO COLLECT

Number of pregnant women who have received zero/one/two/three or more doses of IPTp.

NUMERATOR

Number of pregnant women who have received zero/one/two/three or more doses of IPTp.

DENOMINATOR

None.

DISAGGREGATION

Basic

- Age (10–14, 15–19, 20+)
- IPTp dose (0, 1, 2, 3, 4)
- Geographic area
- Date

Advanced

- ANC visit

MATURITY LEVEL

B.

Longitudinal follow-up and individual identifier are necessary to count the number of doses administered to the same woman.

FREQUENCY

Monthly.

DIGITALIZATION

Disaggregation can be automatic for age, geographic area, date, if the information is already collected with individual identifier.

ALIGNMENT

WHO 100 indicators: Intermittent preventive therapy for malaria during pregnancy *(1)*

HDC facility guidance: Intermittent preventive treatment of malaria during pregnancy (IPTp) coverage *(2)*

Malaria surveillance, monitoring and evaluation: a reference manual: Proportion of pregnant women who received three or more doses of IPTp *(3)*

REFERENCES

1. 2018 global reference list of 100 core health indicators (plus health-related SDGs). Geneva: WHO; 2018 (https://apps.who.int/iris/bitstream/handle/10665/259951/WHO-HIS-IER-GPM-2018.1-eng.pdf, accessed 31 August 2020).
2. Analysis and use of health facility data. In: World Health Organization [website] (https://www.who.int/healthinfo/tools_data_analysis_routine_facility/en/, accessed 31 August 2020).
3. Malaria surveillance, monitoring and evaluation: a reference manual. Geneva: World Health Organization; 2018 (https://apps.who.int/iris/bitstream/handle/10665/272284/9789241565578-eng.pdf, accessed 31 August 2020).

Other

WHO recommendations: Optimizing health worker roles to improve access to key maternal and newborn health interventions through task shifting. Geneva: WHO; 2012 (https://apps.who.int/iris/bitstream/handle/10665/77764/9789241504843_eng.pdf, accessed 31 August 2020).

126. NUMBER OF CHILDREN AGED 3–59 MONTHS WHO RECEIVED ZERO/ONE/TWO/THREE/FOUR OR MORE COURSES OF SEASONAL MALARIA CHEMOPREVENTION (SMC) IN A TRANSMISSION SEASON

COMMENT

Disaggregation is critical to evaluate efficiency and progress of any intervention for children to complete seasonal malaria chemoprevention (SMC) according to national policy.

Specific challenges are critical to tackle:

- If this indicator is done through household assessments, then the timing is key: household assessments should be done right after the SMC distribution period.
- If this indicator is done through individual consultations, this indicator should be monitored only during the transmission season, and is usually very time intensive. As CHWs may not be the only actors involved in SMC distribution, and parents may be charged to deliver some doses for each course, it is critical to coordinate the monitoring of all actors involved in delivering doses.

CHW TASK

SMC delivery.

DENOMINATOR

None.

CHW DATA POINTS TO COLLECT

Number of children aged 3–59 months who received zero/one/two/three/four or more courses of SMC in a transmission season.

NUMERATOR

Number of children aged 3–59 months who received zero/one/two/three/four or more courses of SMC in a transmission season.

DISAGGREGATION

Basic

- Number of SMC doses (n) by course
- Geographic area
- Date

Advanced

- Sex (male, female)

MATURITY LEVEL

B.

Longitudinal follow-up and individual identifier are necessary to count the number of doses administered to the same child.

FREQUENCY

Monthly or at least once a year.

DIGITALIZATION

Disaggregation can be automatic for the age, geographic area, time, if the information is already collected with individual identifier.

ALIGNMENT

Malaria surveillance, monitoring and evaluation: a reference manual: Proportion of children aged 3–59 months who received the full number of courses of SMC per transmission season *(1)*

REFERENCES

1. Malaria surveillance, monitoring and evaluation: a reference manual. Geneva: World Health Organization; 2018 (https://apps.who.int/iris/bitstream/handle/10665/272284/9789241565578-eng.pdf, accessed 31 August 2020).

127. PROPORTION OF PEOPLE CONFIRMED WITH TB OUT OF ALL PEOPLE WHO WERE REFERRED FOR DIAGNOSIS BY CHW

COMMENT

Referral should be done to the specified referral structure – usually the TB diagnostic facility with which the referring CHW is affiliated.

CHW TASK

Referral of people screened positive for TB by CHW and collection of feedback from the TB diagnostic facility on the outcome of the TB diagnostic test.

CHW DATA POINTS TO COLLECT

- Number of people screened for TB symptoms by CHW.
- Number of people referred for TB by CHW for TB diagnosis.
- Number of people confirmed with TB through CHW referral.

NUMERATOR

Number of people who were confirmed with TB through referral by CHW.

DENOMINATOR

Number of people who were referred by CHW for TB diagnosis.

DISAGGREGATION

Basic

- Age (0–4, 5–9, 10–14, 15–19, 20–24, 25–29, 30–34, 35–39, 40–44, 45–49, 50–54, 55–59, 60–64, 65–69, 70–74, 75–79, 80+)
- Gender (male, female, transgender)

Advanced

- TB key population (PLHIV, people who use drugs, miners, prisoners, health workers, indigenous persons, mobile and migrant populations, urban poor)
- HIV status

MATURITY LEVEL

C.

Longitudinal follow-up and data interoperability with both HIV and TB services is key.

FREQUENCY

Monthly.

DIGITALIZATION

Data interoperability with both HIV and TB services is key.

Disaggregation can be automatic for age, geographic area, gender, risk group, HIV status, if the information is already collected with individual identifier.

ALIGNMENT

WHO community engagement in tuberculosis: Number and percentage of new patients with TB (all forms) diagnosed and notified who were referred by CHWs and community volunteers *(1)*

REFERENCES

1. Community engagement in tuberculosis. Geneva: World Health Organization; 2019 (https://www.who.int/tb/areas-of-work/community-engagement/Community_Engagement_TB_2018.pdf, accessed 31 August 2020).

Other

ENGAGE-TB approach: Operational guidance – Integrating community-based tuberculosis activities into the work of nongovernmental and other civil society organizations. Geneva: World Health Organization; 2012 (https://www.who.int/tb/publications/2012/engage_tb_policy/en/, accessed 31 August 2020).

128. PROPORTION OF PEOPLE NOTIFIED WITH TB THROUGH CHW REFERRALS OUT OF ALL PEOPLE NOTIFIED WITH TB

COMMENT

Referral should be done to the specified referral structure – usually the TB treatment centre with which the referring CHW is affiliated.

CHW TASK

Referral of people screened positive for TB for notification to designated treatment centre and share feedback from the TB diagnostic facility on the outcome of the TB diagnostic test.

CHW DATA POINTS TO COLLECT

- Number of people confirmed with TB among those referred for testing.
- Number who are notified with TB through CHW referral.
- Total number of all people notified with TB in the catchment area.

NUMERATOR

Number of people who were confirmed to have TB notified with TB through CHW referral.

DENOMINATOR

Total number of people who were notified with TB in the catchment area.

DISAGGREGATION

Basic

- Age (0–4, 5–9, 10–14, 15–19, 20–24, 25–29, 30–34, 35–39, 40–44, 45–49, 50–54, 55–59, 60–64, 65–69, 70–74, 75–79, 80+)
- Gender (male, female, transgender)

Advanced

- TB key population (PLHIV, people who use drugs, miners, prisoners, health workers, indigenous persons, mobile and migrant populations, urban poor)
- HIV status

MATURITY LEVEL

C.

Longitudinal follow-up and data interoperability with both HIV and TB services is key.

FREQUENCY

Monthly, quarterly, yearly.

DIGITALIZATION

Disaggregation can be automatic for age, geographic area, sex, risk group, HIV status, if the information is already collected with individual identifier.

ALIGNMENT

WHO community engagement in tuberculosis: Number and percentage of new patients with TB (all forms) diagnosed and notified who were referred by CHWs and community volunteers *(1)*

REFERENCES

1. Community engagement in tuberculosis. Geneva: World Health Organization; 2019 (https://www.who.int/tb/areas-of-work/community-engagement/Community_Engagement_TB_2018.pdf, accessed 31 August 2020).

Other

ENGAGE-TB approach: Operational guidance – Integrating community-based tuberculosis activities into the work of nongovernmental and other civil society organizations. Geneva: World Health Organization; 2012 (https://www.who.int/tb/publications/2012/engage_tb_policy/en/, accessed 31 August 2020).

129. PROPORTION OF PEOPLE TO WHOM TB PREVENTIVE TREATMENT (TPT) SUPPORT/ FOLLOW-UP WAS PROVIDED BY CHW

COMMENT

CHWs may be involved with systematic investigation of contacts of TB patients. All contacts (adults and children) screened positive for TB symptoms should be referred for further TB investigation. However, all contacts having no TB symptoms should be referred for assessment of eligibility for TB preventive treatment (TPT). Once deemed eligible, TPT is started. CHWs may be engaged in provision and continuation of TPT, monitoring the emergence of adverse events or TB symptoms during the course, and facilitating completion of the treatment course.

CHW TASK

- Provision of TPT.
- Follow-up and support continuation of TPT.
- Recording and reporting.

CHW DATA POINTS TO COLLECT

Number of people to whom TPT continuation support/ follow-up was provided.

NUMERATOR

Number of people to whom TPT continuation support/ follow-up was provided by CHW.

DENOMINATOR

Total number of people who were eligible started on TPT in the catchment area of CHW.

DISAGGREGATION

Basic

- Age (0–4; 5–9, 10–14, 15–19, 20–24, 25–29, 30–34, 35–39, 40–44, 45–49, 50–54, 55–59, 60–64, 65–69, 70–74, 75–79, 80+)
- Gender (male, female, transgender)
- HIV status
- Type of TPT (6H, 4R, 3HP, 3HR, 1HP)
- TPT started at community level versus facility or basic management unit (BMU) level

Advanced

- TB key population (people who use drugs, miners, prisoners, health workers, indigenous persons, mobile and migrant populations, urban poor)

MATURITY LEVEL

C.

Longitudinal follow-up and data interoperability with both HIV and TB services is key.

FREQUENCY

Monthly.

DIGITALIZATION

Disaggregation can be automatic for age, geographic area, gender, risk group.

ALIGNMENT

WHO community engagement in tuberculosis: Number and percentage of successfully treated new patients with TB (all forms) who received support for treatment adherence from CHWs and community volunteers *(1)*

REFERENCES

1. Community engagement in tuberculosis. Geneva: World Health Organization; 2019 (https://www.who.int/tb/areas-of-work/community-engagement/Community_Engagement_TB_2018.pdf, accessed 31 August 2020).

Other

WHO operational handbook on tuberculosis: module 1: prevention: tuberculosis preventive treatment. Geneva: World Health Organization;2020 (https://www.who.int/publications-detail/who-operational-handbook-on-tuberculosis-module-1-prevention-tuberculosis-preventive-treatment, accessed 31 August 2020).

130. PROPORTION OF PEOPLE TO WHOM TB DISEASE TREATMENT ADHERENCE SUPPORT WAS PROVIDED

COMMENT

CHWs may be involved with provision TB disease treatment to eligible people in the catchment area. Along with this, they may provide adherence support by identifying any adverse event and link to designated health-care facilities for immediate management. CHWs may also help people on treatment continue their treatment by offering ongoing counselling support and linking to appropriate social support mechanisms, thus enabling completion of treatment courses.

CHW TASK

Follow-up and support of TB disease treatment.

CHW DATA POINTS TO COLLECT

Number of people receiving TB treatment to whom treatment adherence support was provided by CHW.

NUMERATOR

Number of people receiving TB treatment to whom treatment adherence support was provided by CHW.

DENOMINATOR

Total number of people receiving TB treatment in the catchment area.

DISAGGREGATION

Basic

- Age (0–4, 5–9, 10–14, 15–19, 20–24, 25–29, 30–34, 35–39, 40–44, 45–49, 50–54, 55–59, 60–64, 65–69, 70–74, 75–79, 80+)
- Gender (male, female, transgender)

Advanced

- TB key population (PLHIV, people who use drugs, miners, prisoners, health workers, indigenous persons, mobile and migrant populations, urban poor)
- Drug sensitivity: DS and DR-TB (MDR/XDR/RR)

MATURITY LEVEL

C.

Longitudinal follow-up is key.

FREQUENCY

Monthly.

DIGITALIZATION

Disaggregation can be automatic for age, geographic area, gender, risk group.

ALIGNMENT

WHO community engagement in tuberculosis: Number and percentage of successfully treated new patients with TB (all forms) who received support for treatment adherence from CHWs and community volunteers *(1)*

REFERENCES

1. Community engagement in tuberculosis. Geneva: World Health Organization; 2019 (https://www.who.int/tb/areas-of-work/community-engagement/Community_Engagement_TB_2018.pdf, accessed 31 August 2020).

Other

ENGAGE-TB approach: Operational guidance – Integrating community-based tuberculosis activities into the work of nongovernmental and other civil society organizations. Geneva: World Health Organization; 2012 (https://www.who.int/tb/publications/2012/engage_tb_policy/en/, accessed 31 August 2020).

131. TB CONTACT SCREENING

COMMENT

Contacts of TB patients, particularly household contacts, have many times more risk to acquire TB infection and hence progress to TB disease compared to the general population. Therefore, systematic contact investigation is an integral part of both active TB case finding as well as programmatic management of TPT services. CHWs are strategically located close to TB patient residence and hence play an important role in systematic contact investigation and referral for diagnosis of TB infection (no TB symptoms) or TB disease (TB symptoms present).

CHW TASK

- TB household contact screening and referral.
- Recording and reporting.

CHW DATA POINTS TO COLLECT

- Number of contacts of bacteriologically confirmed TB patients who were evaluated for TB symptoms by CHW.
- Number of contacts of bacteriologically confirmed TB patients who had TB symptoms, referred for TB diagnosis.
- Number of contacts of bacteriologically confirmed TB patients who had no TB symptoms, referred for diagnosis of TB infection (latent TB infection).

NUMERATOR

Number of contacts of bacteriologically confirmed TB patients in the catchment area of CHW, who were referred for diagnosis of TB disease or TB infection (latent TB).

DENOMINATOR

Number of contacts of bacteriologically confirmed TB patients in the catchment area of the CHW.

DISAGGREGATION

Basic

- Age (0–4, 5–9, 10–14, 15–19, 20–24, 25–29, 30–34, 35–39, 40–44, 45–49, 50–54, 55–59, 60–64, 65–69, 70–74, 75–79, 80+)
- Gender (male, female, transgender)
- HIV status

Advanced

- TB evaluation or TB testing (sputum or other)
- TB key population (people who use drugs, miners, prisoners, health workers, indigenous persons, mobile and migrant populations, urban poor)
- Index case drug sensitivity: DS and DR-TB (MDR/XDR/RR)

MATURITY LEVEL

D.

FREQUENCY

Monthly.

DIGITALIZATION

Disaggregation can be automatic for age, geographic area, gender, mode of TB evaluation.

ALIGNMENT

WHO Implementing the end TB strategy: the essentials: Contact investigation coverage (%): Number of contacts of people with bacteriologically confirmed TB who were evaluated for TB divided by the number eligible, expressed as a percentage *(1)*

REFERENCES

1. Implementing the end TB strategy: the essentials. Geneva: World Health Organization; 2015 (https://www.who.int/tb/publications/2015/end_tb_essential.pdf, accessed 31 August 2020).

Other

WHO operational handbook on tuberculosis: module 1: prevention: tuberculosis preventive treatment. Geneva: World Health Organization;2020 (https://www.who.int/publications-detail/who-operational-handbook-on-tuberculosis-module-1-prevention-tuberculosis-preventive-treatment, accessed 31 August 2020).

132. PROPORTION OF PEOPLE WHO WERE SUCCESSFULLY TREATED AND WHO BENEFITED FROM COMMUNITY-BASED TB TREATMENT ADHERENCE SUPPORT

CHW TASK

Follow up and provide any form of community-based treatment support (such as psychosocial support, home visits, capacity-building on income-generating activities, treatment literacy support, etc.).

CHW DATA POINTS TO COLLECT

Number of people who were successfully treated (cured or completed treatment) out of all people who benefited from any form of community-based treatment support.

NUMERATOR

Number of people who were successfully treated and who benefited from any form of community-based treatment support.

DENOMINATOR

Total number of people to whom TB disease treatment adherence support was provided at community level.

DISAGGREGATION

Basic

- Age (0–4, 5–9, 10–14, 15–19, 20–24, 25–29, 30–34, 35–39, 40–44, 45–49, 50–54, 55–59, 60–64, 65–69, 70–74, 75–79, 80+)
- Gender (male, female, transgender)

Advanced

- TB key population (PLHIV, people who use drugs, miners, prisoners, health workers, indigenous persons, mobile and migrant populations, urban poor)
- Drug sensitivity: DS and DR-TB (MDR/XDR/RR)

MATURITY LEVEL

C.

Longitudinal follow-up is key.

FREQUENCY

Monthly, quarterly, yearly.

DIGITALIZATION

Disaggregation can be automatic for age, geographic area, gender, risk group.

ALIGNMENT

WHO community engagement in tuberculosis: Number and percentage of successfully treated new patients with TB (all forms) who received support for treatment adherence from CHWs and community volunteers *(1)*

REFERENCES

1. Community engagement in tuberculosis. Geneva: World Health Organization; 2019 (https://www.who.int/tb/areas-of-work/community-engagement/Community_Engagement_TB_2018.pdf, accessed 31 August 2020).

Other

ENGAGE-TB approach: Operational guidance – Integrating community-based tuberculosis activities into the work of nongovernmental and other civil society organizations. Geneva: World Health Organization; 2012 (https://www.who.int/tb/publications/2012/engage_tb_policy/en/, accessed 31 August 2020).

133. PROPORTION OF INDIVIDUALS WHO STARTED TPT WHO COMPLETE THE COURSE

COMMENT

The extent of protection from TB disease is directly proportional to the duration of TPT completed by eligible people. To ensure optimal protection, it is important to ensure a complete course of TPT. TPT may be considered completed when an individual takes 80% or more (90% for 3HP, i.e. 11/12 weekly doses) of the prescribed number of doses of treatment within 133% of the scheduled duration of the respective TPT regimen, and remains well or asymptomatic during the entire period.

CHW TASK

Delivery, follow-up or support of TPT.

CHW DATA POINTS TO COLLECT

- Number of people started on TPT who completed the course during the reporting period.
- Number of people started on TPT.

NUMERATOR

Number of people who received TPT through CHW who completed the course during the reporting period.

DENOMINATOR

Number of people started on TPT in the catchment area of designated health-care facility.

DISAGGREGATION

Basic

- Age (0–4, 5–9, 10–14, 15–19, 20–24, 25–29, 30–34, 35–39, 40–44, 45–49, 50–54, 55–59, 60–64, 65–69, 70–74, 75–79, 80+)
- Gender (male, female, transgender)
- Geographic area
- TPT indication:
  - PLHIV.
  - Household contact.
- TPT started at community level versus facility or BMU level

Advanced

- TB key population (PLHIV, people who use drugs, miners, prisoners, health workers, indigenous persons, mobile and migrant populations, urban poor)

MATURITY LEVEL

C.

Data interoperability with TB services is key.

FREQUENCY

Monthly.

DIGITALIZATION

Data interoperability with TB services is key.

Disaggregation can be automatic for age, geographic area, gender, key population type, if the information is already collected with individual identifier.

A preset menu can also facilitate the collection of the therapy indication.

ALIGNMENT

None.

REFERENCES

1. WHO operational handbook on tuberculosis: module 1: prevention: tuberculosis preventive treatment. Geneva: World Health Organization;2020 (https://www.who.int/publications-detail/who-operational-handbook-on-tuberculosis-module-1-prevention-tuberculosis-preventive-treatment, accessed 31 August 2020).

134. PROPORTION OF PEOPLE WITH TB REFERRED BY A CHW TO A HEALTH FACILITY TO MANAGE DRUG SIDE EFFECTS

COMMENT

CHWs (who are literate) should be encouraged to report secondary effects, preferably to the clinician who prescribed the treatment, or directly to the pharmacovigilance center.

CHW TASK

Refer TB patients to health facility when there is suspicion of drug side effects.

CHW DATA POINTS TO COLLECT

Number of people with TB with drug side effects referred to a health facility by a CHW to manage drug side effects.

NUMERATOR

Number of people with TB with drug side effects referred to a health facility by a CHW to manage drug side effects.

DENOMINATOR

Total number of people treated for TB in the catchment area.

DISAGGREGATION

Basic

- Age (0–4, 5–9, 10–14, 15–19, 20–24, 25–29, 30–34, 35–39, 40–44, 45–49, 50–54, 55–59, 60–64, 65–69, 70–74, 75–79, 80+)
- Gender (male, female, transgender)
- Geographic area
- TPT, TB disease treatment

Advanced

- TB key population (PLHIV, people who use drugs, miners, prisoners, health workers, indigenous persons, mobile and migrant populations, urban poor)

MATURITY LEVEL

C.

Longitudinal follow-up is key and interoperability with facility/BMU services.

FREQUENCY

Monthly.

DIGITALIZATION

Disaggregation can be automatic, especially if there is interoperability with HIV/TB status, for age, gender, geographic area, if feasible.

ALIGNMENT

None.

REFERENCES

1. A practical handbook on the pharmacovigilance of medicines used in the treatment of tuberculosis: enhaving the safety of the TB patient. Geneva: World Health Organization; 2012 (https://www.who.int/medicines/publications/Pharmaco_TB_web_v3.pdf, accessed 31 August 2020).

135. NUMBER OF SUSPECTED NEGLECTED TROPICAL DISEASE (NTD) CASES REPORTED

COMMENT

Neglected tropical diseases (NTDs) affect poor populations living in remote areas where access to health facilities is limited. CHWs have a key role to play in those communities to improve access to diagnosis and treatment. CHWs will detect suspected NTD cases and refer them to the relevant health facility or report them to the health facility or district public health officers in order to trigger outreach activities.

This activity is relevant for all the NTDs, and even more important for NTDs targeted for elimination or eradication.

CHW TASK

CHWs regularly screen their population for different diseases. CHWs should also be trained in screening their population for endemic NTDs and to refer them to the health facility.

CHW DATA POINTS TO COLLECT

Number of suspected NTD cases detected.

NUMERATOR

Number of suspected NTD cases reported.

DENOMINATOR

None.

DISAGGREGATION

Basic

- Age group (0–5, 5–9, 10–14, 15–19, 20–24, 25–29, 30–34, 35–39, 40–44, 45–49, 50–54, 55–59, 60–64, 65–69, 70–74, 75–79, 80+)
- Gender (male, female, transgender)
- NTD

Advanced

- Residential status (resident/migrant)

MATURITY LEVEL

C.

FREQUENCY

The data can be collected each time the CHW is doing household assessment, or during consultations at the health post.

Data should be reported on a monthly basis.

ALIGNMENT

SDG: 3.3: By 2030, end the epidemics of AIDS, tuberculosis, malaria and NTDs and combat hepatitis, waterborne diseases and other communicable diseases *(1)*

WHO NTD Roadmap 2011–2020 *(2)*

WHO NTD Roadmap 2021–2030 *(3)*

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2. Accelerating work to overcome the global impact of neglected tropical diseases: a roadmap for implementation. Geneva: World Health Organization; 2012 (https://www.who.int/neglected_diseases/NTD_RoadMap_2012_Fullversion.pdf, accessed 31 August 2020).
3. Ending the neglect to attain the Sustainable Development Goals: a road map for neglected tropical diseases 2021–2030. Geneva: World Health Organization; 2020 (https://www.who.int/neglected_diseases/NTD_RoadMap_2012_Fullversion.pdf, accessed 31 August 2020).

136. NUMBER OF RUMOURS OF GUINEA WORM DISEASE/DRACUNCULIASIS CASES REPORTED

COMMENT

Guinea worm is targeted for eradication. The involvement of CHWs to detect rumors of guinea worm is key in order to detect any potential case and demonstrate the sensitivity of the surveillance system. Rumours of dracunculiasis are defined as information about an alleged case of dracunculiasis (guinea worm disease) obtained from any source (informants).

CHW TASK

CHWs regularly go house to house for active case finding, or can also receive community members at a peripheral health post. CHWs should notify any rumour of guinea worm to the closest health facility.

CHW DATA POINTS TO COLLECT

Number of rumours of guinea worm disease/ dracunculiasis cases reported.

NUMERATOR

Number of rumours of guinea worm disease/ dracunculiasis cases reported.

DENOMINATOR

None.

DISAGGREGATION

Basic

- Age group (0–5, 5–9, 10–14, 15–19, 20+)
- Gender (male, female, transgender)

Advanced

None.

MATURITY LEVEL

C.

FREQUENCY

The data can be collected each time the CHW is doing household assessment, or during consultations at the health post.

Data should be reported on a monthly basis.

ALIGNMENT

SDG: 3.3: By 2030, end the epidemics of AIDS, tuberculosis, malaria and NTDs and combat hepatitis, waterborne diseases and other communicable diseases *(1)*

WHO NTD Roadmap 2011–2020 *(2)*

WHO NTD Roadmap 2021–2030 *(3)*

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137. NUMBER OF RUMOURED YAWS CASES REPORTED

COMMENT

Yaws, a systemic infection affecting the skin and, more rarely, bone, is caused by the bacterium Treponema pertenue, a subspecies of T. pallidum, which causes syphilis. However, yaws is not sexually transmitted. The disease is often first recognized in children but may affect all ages; it is spread by direct contact between individuals. Yaws presents with one or multiple skin lesions, which appear as small lumps or nodules. These may have a red or yellow surface colour and often feel soft, pebbled or bumpy. These lumps may break down to leave an area of ulceration in the centre of the nodule or appear in the shape of a small volcano.

Yaws is targeted for eradication. The involvement of CHWs to detect rumours of yaws is key in order to detect any potential case and demonstrate the sensitivity of the surveillance system.

CHW TASK

CHWs regularly go house to house for active case finding or can also receive community members at a peripheral health post. CHWs should notify and refer any rumoured yaws case to the closest health facility.

CHW DATA POINTS TO COLLECT

Number of rumoured yaws cases detected.

NUMERATOR

Number of rumoured yaws cases reported.

DENOMINATOR

None.

DISAGGREGATION

Basic

- Age group (0–5, 5–9, 10–14 years, 15–19, 20+)
- Gender (male, female, transgender)

Advanced

- Residential status (resident/migrant)

MATURITY LEVEL

C.

FREQUENCY

The data can be collected each time the CHW is doing household assessment, or during consultations at the health post.

Data should be reported on monthly basis at the latest (immediate notification to trigger outreach intervention from the health-care workers at health facility of the distract public health officers is recommended).

ALIGNMENT

SDG: 3.3: By 2030, end the epidemics of AIDS, tuberculosis, malaria and NTDs and combat hepatitis, waterborne diseases and other communicable diseases *(1)*

WHO NTD Roadmap 2011–2020 *(2)*

WHO NTD Roadmap 2021–2030 *(3)*

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Other

Recognizing neglected tropical diseases through changes on the skin: a training guide for front-line health workers. Geneva: World Health Organization; 2018 (https://apps.who.int/iris/bitstream/handle/10665/272723/9789241513531-eng.pdf, accessed 31 August 2020).

138. NUMBER OF PEOPLE REFERRED TO HEALTH CENTRE FOR DIAGNOSIS OR TREATMENT OF NTDs

COMMENT

CHWs may not be able to diagnose or treat NTD cases. However, they should be trained in suspecting NTDs and to refer the patients to an appropriate health facility for proper diagnosis and treatment.

CHW TASK

Referral of patients to the appropriate health facility.

CHW DATA POINTS TO COLLECT

Information about each NTD suspected cases referred to the health centre.

NUMERATOR

Number of people referred to health centre for diagnosis or treatment of NTDs.

DENOMINATOR

None.

DISAGGREGATION

Basic

- Age group (0–5, 5–9, 10–14, 15–19, 20+)
- Gender (male, female, transgender)
- Type of NTD

Advanced

- Residential status (resident/migrant)

MATURITY LEVEL

C.

FREQUENCY

Data to be reported on monthly, quarterly or yearly basis.

ALIGNMENT

SDG: 3.3: By 2030, end the epidemics of AIDS, tuberculosis, malaria and NTDs and combat hepatitis, waterborne diseases and other communicable diseases *(1)*

WHO NTD Roadmap 2011–2020 *(2)*

WHO NTD Roadmap 2021–2030 *(3)*

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3. Ending the neglect to attain the Sustainable Development Goals: a road map for neglected tropical diseases 2021–2030. Geneva: World Health Organization; 2020 (https://www.who.int/neglected_diseases/NTD_RoadMap_2012_Fullversion.pdf, accessed 31 August 2020).

139. GEOGRAPHICAL COVERAGE OF PREVENTIVE CHEMOTHERAPY (PC) FOR TARGETED NTDs

COMMENT

Preventive chemotherapy (PC) is a major strategy in the fight against NTDs. PC consists of wide-scale delivery of safe, quality-assured medicines, either alone or in combination, at regular intervals to entire population groups.

It is particularly relevant for lymphatic filariasis, onchocerciasis, schistosomiasis, soil-transmitted helminthiases, taeniasis, trachoma and yaws.

Data collected by the CHWs can be used for data aggregation at upper level (district, implementation unit, national).

CHW TASK

CHWs are part of the team in charge of the PC campaigns and can be involved in different activities: mobilization, distribution, evaluation.

CHW DATA POINTS TO COLLECT

Number of communities/villages/localities receiving PC against NTDs according to national policy.

NUMERATOR

Number of communities/villages/localities receiving PC against NTDs according to national policy.

DENOMINATOR

Number of communities/villages/localities requiring PC against NTDs according to national policy.

DISAGGREGATION

Basic

- Disease (lymphatic filariasis, onchocerciasis, schistosomiasis, soil-transmitted helminthiases, taeniasis, trachoma, yaws)
- Type of PC (combination of medicines to cover endemic diseases in integrated manner)

Advanced

None.

MATURITY LEVEL

A.

FREQUENCY

After each mass-drug administration campaign planned for the reporting year.

ALIGNMENT

SDG: 3.3: By 2030, end the epidemics of AIDS, tuberculosis, malaria and NTDs and combat hepatitis, waterborne diseases and other communicable diseases *(1)*

WHO NTD Roadmap 2011–2020 *(2)*

WHO NTD Roadmap 2021–2030 *(3)*

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3. Ending the neglect to attain the Sustainable Development Goals: a road map for neglected tropical diseases 2021–2030. Geneva: World Health Organization; 2020 (https://www.who.int/neglected_diseases/NTD_RoadMap_2012_Fullversion.pdf, accessed 31 August 2020).

140. POPULATION COVERAGE OF PC FOR TARGETED NTDs

COMMENT

PC is a major strategy in the fight against NTDs, consisting of wide-scale delivery of safe, quality-assured medicines, either alone or in combination, at regular intervals to entire population groups.

It is particularly relevant for lymphatic filariasis, onchocerciasis, schistosomiasis, soil-transmitted helminthiases, taeniasis, trachoma and yaws.

The population targeted for PC depends on the disease:

- Lymphatic filariasis, onchocerciasis, trachoma and yaws: Entire community population
- Soil-transmitted helminthiases: Children 1–14 years of age and women of childbearing age
- Schistosomiasis: Children 5–14 years of age and adults at high risk
- Taeniasis: Children 5–14 years of age and adults.

PC programmes do not use the term "deworming", which is mainly associated with treatment of children. Eligible groups for treatment also depend on medicines (PC type) distributed:

- MDA1, MDA3 and T2: 5 years old and above
- MDA2: 2 years old and above
- T1: 5–14 years old
- T3: 1–14 years old.

This involvement of CHWs is key in order to achieve high population coverage of such activity.

CHW TASK

CHWs are part of the team in charge of the PC campaigns and can be involved in different activities such as mobilization, distribution and evaluation.

CHW DATA POINTS TO COLLECT

- Number of people receiving a dose of PC against NTDs according to national policy.
- Number of people targeted for PC against NTDs according to national policy.

NUMERATOR

Number of people receiving a dose of PC against NTDs according to national policy.

DENOMINATOR

Number of people targeted for PC against NTDs according to national policy.

DISAGGREGATION

Basic

- Disease (lymphatic filariasis, onchocerciasis, schistosomiasis, soil-transmitted helminthiases, taeniasis, trachoma, yaws)
- Type of PC (combination of medicines to cover endemic diseases on integrated manner)
- Age group (0–5, 5–9, 10–14, 15–19, 20+)
- Gender (male, female, transgender)

Advanced

None.

MATURITY LEVEL

A.

FREQUENCY

After each mass-drug administration campaign planned for the reporting year.

ALIGNMENT

SDG: 3.3: By 2030, end the epidemics of AIDS, tuberculosis, malaria and NTDs and combat hepatitis, waterborne diseases and other communicable diseases *(1)*

WHO NTD Roadmap 2011–2020 *(2)*

WHO NTD Roadmap 2021–2030 *(3)*

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141. PROPORTION OF HOUSEHOLDS IN THE TARGETED COMMUNITIES THAT RECEIVED SOCIAL MOBILIZATION/AWARENESS CAMPAIGNS ON NTDs

COMMENT

Social mobilization is key in order to ensure the success of several NTD interventions in the community with good coverage. CHWs have a key role to play in this social mobilization.

This indicator is relevant to all NTDs with community interventions and to all NTD interventions (active case finding, PC, one health approach and vector control).

CHW TASK

Mobilization of households prior or during NTD-related interventions or in order to raise awareness about the NTD endemic in the targeted community.

CHW DATA POINTS TO COLLECT

- Number of households in the targeted communities that received social mobilization/awareness campaigns on NTDs.
- Number of households in the targeted communities.

NUMERATOR

Number of households in the targeted communities that received social mobilization/awareness campaigns on NTDs.

DENOMINATOR

Number of households in the communities targeted for social mobilization/awareness campaigns on NTDs.

DISAGGREGATION

Basic

- NTD intervention (case management, one health approach, PC, vector control)
- NTD

Advanced

None.

MATURITY LEVEL

A.

FREQUENCY

After each mobilization/awareness campaign planned for the reporting year.

ALIGNMENT

SDG: 3.3: By 2030, end the epidemics of AIDS, tuberculosis, malaria and NTDs and combat hepatitis, waterborne diseases and other communicable diseases *(1)*

WHO NTD Roadmap 2011–2020 *(2)*

WHO NTD Roadmap 2021–2030 *(3)*

REFERENCES

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142. NUMBER OF PEOPLE BITTEN BY AN ANIMAL (ANIMAL BITE CASES) IN THE COMMUNITY, BY ANIMAL

COMMENT

Animal bites pose a major public health problem in children and adults worldwide. The health impacts of animal bites are dependent on the type and health of the animal species, the size and health of the bitten person, and accessibility to appropriate health care. Numerous animal species have the potential to bite humans; however, the most important are those arising from snakes, dogs, cats and monkeys. In relation to NTDs, the most important bites to report are dog bites (risk of rabies infection) and snakebites. We intend to measure the number of people who are victims of one or multiple animal bites. An "animal bite case" is defined as a human who was bitten by an animal (or a human), regardless of whether it consisted of a single or multiple (animal) bites.

The CHWs are therefore requested to report on the number of people bitten by animal in the community, by animal species.

CHW TASK

First aid, recording bite cases (people bitten by an animal) during household assessment or consultation at health posts and referral.

CHW DATA POINTS TO COLLECT

Number of people bitten by an animal (animal bite cases) in the community, by animal.

NUMERATOR

Number of people bitten by an animal (animal bite cases) in the community, by animal.

DENOMINATOR

None.

DISAGGREGATION

Basic

- Age group (0–5, 5–9, 10–14, 15–19, 20+)
- Gender (male, female, transgender)
- Animal species (dog, cat, bat, livestock, monkey, wildlife, snake, scorpion, other animal)

Advanced

None.

MATURITY LEVEL

C.

FREQUENCY

Data to be reported on monthly, quarterly or yearly basis.

ALIGNMENT

SDG: 3.3: By 2030, end the epidemics of AIDS, tuberculosis, malaria and NTDs and combat hepatitis, waterborne diseases and other communicable diseases *(1)*

WHO NTD Roadmap 2011–2020 *(2)*

WHO NTD Roadmap 2021–2030 *(3)*

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143. NUMBER OF DEATHS IN THE COMMUNITY OCCURRING WITHIN THREE MONTHS AFTER A SNAKEBITE OR A DOG BITE

COMMENT

Some NTDs are fatal if left untreated. Monitoring deaths from NTD cases is one way of ensuring that no one is left behind.

CHWs are not expected to define the cause of death; however, if the person was known to have been affected by a NTD, or if the death can be clearly related to an accident such as a snakebite, the community death can be reported to upper levels.

Several NTDs can be fatal if left untreated (Chagas disease, dengue, human African trypanosomiasis [sleeping sickness], rabies, snakebites, visceral leishmaniasis), but only a few can be easily identified and reported by CHWs if the death happens in the community.

The CHWs are requested to report all deaths happening in the community with recent history of an animal bite (within three months after a snakebite or a dog bite), stratified by animal (snake, dog). This will be a proxy for the number of deaths due to snakebites or rabies.

CHW TASK

CHWs regularly visit the households in their area and report any death from a person known as being affected by a NTD.

CHW DATA POINTS TO COLLECT

Number of deaths in the community occurring within three months after a snakebite or a dog bite.

NUMERATOR

Number of deaths in the community occurring within three months after a snakebite or a dog bite.

DENOMINATOR

None.

DISAGGREGATION

Basic

- Age group (0–5, 5–9, 10–14, 15–19, 20+)
- Gender (male, female, transgender)
- Biter animal (snake or dog)

Advanced

- Residential status (resident/migrant)

MATURITY LEVEL

C.

FREQUENCY

The data can be collected each time there is a community death.

Data should be reported on a quarterly basis or every six months.

ALIGNMENT

SDG: 3.3: By 2030, end the epidemics of AIDS, tuberculosis, malaria and NTDs and combat hepatitis, waterborne diseases and other communicable diseases *(1)*

WHO NTD Roadmap 2011–2020 *(2)*

WHO NTD Roadmap 2021–2030 *(3)*

REFERENCES

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144. NUMBER OF PEOPLE SCREENED FOR SKIN LESIONS CONSISTENT WITH NTDs (AND POPULATION COVERAGE)

COMMENT

NTDs with skin manifestations (skin NTDs) share commonalities that allow for integration of the different interventions to control them wherever they are co-endemic. In this context, "integration" refers to the combination of different activities that can be deployed to control diseases. It contributes to greater effectiveness of the interventions by reducing duplications, delays in diagnosis, and the cost for patients and health systems. It also promotes efficiency and effectiveness; hence, benefits are obtained at a lower cost than with an individual approach. Integration also enhances the knowledge of trained workers and village volunteers, and contributes to strengthening the health system.

Ten groups of NTDs present skin manifestation: Buruli ulcer, cutaneous leishmaniasis and post kala-azar dermal leishmaniasis [PKDL], dracunculiasis or guinea worm disease, leprosy, lymphatic filariasis (lymphoedema and hydrocele), mycetoma and other deep mycosis, onchocerciasis, trachoma (trichiasis), scabies and other ectoparasites and yaws. Guinea worm disease and yaws are two skin NTDs targeted for eradication.

Having CHWs regularly screen their population for skin lesions and trained to recognize skin NTDs and refer them to health facilities would help in achieving these targets.

CHW TASK

CHWs regularly screen their population for skin lesions and are trained to recognize skin NTDs and refer them to health facilities.

CHW DATA POINTS TO COLLECT

- Number of people screened for skin NTDs.
- Population targeted for skin NTD screening.

NUMERATOR

Number of people screened for skin NTDs.

DENOMINATOR

Population targeted for skin NTD screening.

DISAGGREGATION

Basic

- Age group (0–5, 5–9, 10–14, 15–19, 20+)
- Gender (male, female, transgender)

Advanced

None.

MATURITY LEVEL

A.

FREQUENCY

The indicator will be monitored on an annual basis, but data can be collected and reported after each campaign/household assessment.

ALIGNMENT

SDG: 3.3: By 2030, end the epidemics of AIDS, tuberculosis, malaria and NTDs and combat hepatitis, waterborne diseases and other communicable diseases *(1)*

WHO NTD Roadmap 2011–2020 *(2)*

WHO NTD Roadmap 2021–2030 *(3)*

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Other

Skin NTDS. In: World Health Organization [website] (https://www.who.int/neglected_diseases/skin-ntds/en/, accessed 31 August 2020).

Recognizing neglected tropical diseases through changes on the skin: a training guide for front-line health workers. Geneva: World Health Organization; 2018 (https://apps.who.int/iris/bitstream/handle/10665/272723/9789241513531-eng.pdf, accessed 31 August 2020).

145. NUMBER OF NTD CASES THAT RECEIVED ADEQUATE/RECOMMENDED WOUND CARE

COMMENT

Inappropriate, ineffective and harmful treatment of NTD-derived wounds can occur as a consequence of lack of access to health-care services or lack of knowledge about the disease condition. The indicator is relevant for early detection, prevention of further damage, and progression of skin NTD morbidity.

This indicator applies not only for the NTDs with skin manifestation (skin NTDs) but also for animal bites (notably snake and dog bites). Ten groups of NTDs present skin manifestation: Buruli ulcer, cutaneous leishmaniasis and PKDL, dracunculiasis or guinea worm disease, leprosy, lymphatic filariasis (lymphoedema and hydrocele), mycetoma and other deep mycosis, onchocerciasis, trachoma (trichiasis), scabies and other ectoparasites and yaws.

CHW TASK

During the household assessment or consultation, CHWs have an educational role to play in order to ensure adequate wound care, according to instructions given at the health facility level. They may also refer the patient to the health facility if needed.

CHW DATA POINTS TO COLLECT

- Number of NTD cases that received adequate/recommended wound care.
- Number of NTD cases presenting wound requiring care.

NUMERATOR

NTD cases who received adequate/recommended wound care.

DENOMINATOR

Number of NTD cases presenting wound requiring care.

DISAGGREGATION

Basic

- Age group (0–5, 5–9, 10–14, 15–19, 20+)
- Gender (male, female, transgender)
- NTD

Advanced

- Residential status (resident/migrant)

MATURITY LEVEL

C.

FREQUENCY

The data can be collected each time the CHW is doing household assessment, or during consultations at the health post.

Data should be reported on a monthly basis.

ALIGNMENT

SDG: 3.3: By 2030, end the epidemics of AIDS, tuberculosis, malaria and NTDs and combat hepatitis, waterborne diseases and other communicable diseases *(1)*

WHO NTD Roadmap 2011–2020 *(2)*

WHO NTD Roadmap 2021–2030 *(3)*

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3. Ending the neglect to attain the Sustainable Development Goals: a road map for neglected tropical diseases 2021–2030. Geneva: World Health Organization; 2020 (https://www.who.int/neglected_diseases/NTD_RoadMap_2012_Fullversion.pdf, accessed 31 August 2020).

Other

Wound and lymphoedema management. Geneva: World Health Organization; 2010 (https://apps.who.int/iris/bitstream/handle/10665/44279/9789241599139_eng.pdf, accessed 31 August 2020).

146. NUMBER OF PEOPLE SCREENED FOR SIGNS AND SYMPTOMS OF VISCERAL LEISHMANIASIS (VL) AND/OR PKDL (AND POPULATION COVERAGE)

COMMENT

Visceral leishmaniasis (VL) is a life-threatening NTD targeted for elimination as a public health problem in Bangladesh, India and Nepal. Active case finding for VL cases in endemic communities, involving CHWs, is a key part of the strategy to achieve elimination as a public health problem. VL cases should be detected as soon as possible and referred to the health facility for diagnosis and treatment.

Post kala-azar dermal leishmaniasis (PKDL) is considered as a sequela of VL that appears after patients have apparently been cured of VL. PKDL has also been reported in patients without a history of VL. PKDL is a non-life-threatening skin condition and does not affect daily activities in the majority of cases, resulting in poor treatment-seeking behaviour. However, PKDL cases can act as reservoir of VL and hence represent a challenge in the elimination of VL.

CHW TASK

- CHWs regularly screen their population for different diseases. VL being a fatal disease, CHWs should be trained to recognize VL signs and symptoms and to refer suspected cases to a health facility. In countries where VL is targeted for elimination as public health problem, CHWs should also be trained in screening their population for PKDL, as people affected by this non-fatal form of the disease may play a role of being a reservoir for VL.
- Once a case has been confirmed, CHWs should also help to follow-up during and after treatment in order to detect treatment failure or PKDL cases.

CHW DATA POINTS TO COLLECT

- Number of people screened for signs and symptoms of VL and/or PKDL in the catchment area.
- Population living in the catchment area.

NUMERATOR

Number of people screened for signs and symptoms of VL and/or PKDL in the catchment area.

DENOMINATOR

Population living in the catchment area.

DISAGGREGATION

Basic

- Age group (0–5, 5–9, 10–14, 15–19, 20+)
- Gender (male, female, transgender)

Advanced

None.

MATURITY LEVEL

A.

FREQUENCY

The data can be collected each time the CHW is doing household assessment, or during consultations at the health post.

Data should be reported on a monthly basis.

ALIGNMENT

SDG: 3.3: By 2030, end the epidemics of AIDS, tuberculosis, malaria and NTDs and combat hepatitis, waterborne diseases and other communicable diseases *(1)*

WHO NTD Roadmap 2011–2020 *(2)*

WHO NTD Roadmap 2021–2030 *(3)*

REFERENCES

1. Sustainable Development Goals. SDG indicators metadata repository. In: United Nations Statistics Division [website] (https://unstats.un.org/sdgs/metadata/, accessed 31 August 2020).
2. Accelerating work to overcome the global impact of neglected tropical diseases: a roadmap for implementation. Geneva: World Health Organization; 2012 (https://www.who.int/neglected_diseases/NTD_RoadMap_2012_Fullversion.pdf, accessed 31 August 2020).
3. Ending the neglect to attain the Sustainable Development Goals: a road map for neglected tropical diseases 2021–2030. Geneva: World Health Organization; 2020 (https://www.who.int/neglected_diseases/NTD_RoadMap_2012_Fullversion.pdf, accessed 31 August 2020).

Other

Process of validation of elimination of kala-azar as a public health problem in South-East Asia. New Delhi: World Health Organization Regional Office for South-East Asia; 2016 (https://www.who.int/leishmaniasis/resources/Validation_of_elimination_of_VL_as_a_public_health_prob_SEARO/en/, accessed 31 August 2020).

Post-kala-azar dermal leishmaniasis: a manual for case management and control: Report of a WHO consultative meeting, Kolkata, India, 2–3 July 2012. Geneva: World Health Organization; 2013 (https://apps.who.int/iris/bitstream/handle/10665/78608/9789241505215_eng.pdf, accessed 31 August 2020).

The post Kala-azar dermal leishmaniasis (PKDL) atlas: A manual for health workers. Geneva: World Health Organization; 2012 (https://www.who.int/leishmaniasis/resources/9789241504102/en/, accessed 31 August 2020).

147. PROPORTION OF PEOPLE PRESENTING HEMATURIA, EITHER VISIBLE HEMATURIA REPORTED BY THE PATIENT OR MICRO-HEMATURIA DETECTED BY A POSITIVE DIPSTICK

COMMENT

Schistosomiasis, also called bilharzia, is disease caused by infection with freshwater parasitic worms in certain tropical and subtropical countries. Hematuria is one of the symptoms of urogenital schistosomiasis, which can either be orally reported by the case (visible hematuria) or detected by using urine dipsticks (micro-hematuria).

CHW TASK

CHWs can screen for micro-hematuria by using the urine dipstick, or for hematuria by asking regular community members in an endemic area, in order to detect schistosomiasis and refer the patient.

CHW DATA POINTS TO COLLECT

- Number of individuals reporting visible hematuria or with positive dipstick for micro-hematuria.
- Number of individuals screened.

NUMERATOR

Number of individuals reporting visible hematuria or with positive dipstick for micro-hematuria.

DENOMINATOR

Number of individuals screened.

DISAGGREGATION

Basic

- Age group (0–5, 5–9, 10–14, 15–19, 20+)
- Gender (male, female, transgender)

Advanced

- Residential status (resident/migrant)

MATURITY LEVEL

B.

FREQUENCY

The data can be collected each time the CHW is doing household assessment, or during consultations at the health post.

Data should be reported on monthly basis.

ALIGNMENT

SDG: 3.3: By 2030, end the epidemics of AIDS, tuberculosis, malaria and NTDs and combat hepatitis, waterborne diseases and other communicable diseases *(1)*

WHO NTD Roadmap 2011–2020 *(2)*

WHO NTD Roadmap 2021–2030 *(3)*

REFERENCES

1. Sustainable Development Goals. SDG indicators metadata repository. In: United Nations Statistics Division [website] (https://unstats.un.org/sdgs/metadata/, accessed 31 August 2020).
2. Accelerating work to overcome the global impact of neglected tropical diseases: a roadmap for implementation. Geneva: World Health Organization; 2012 (https://www.who.int/neglected_diseases/NTD_RoadMap_2012_Fullversion.pdf, accessed 31 August 2020).
3. Ending the neglect to attain the Sustainable Development Goals: a road map for neglected tropical diseases 2021–2030. Geneva: World Health Organization; 2020 (https://www.who.int/neglected_diseases/NTD_RoadMap_2012_Fullversion.pdf, accessed 31 August 2020).

148. PROPORTION OF PEOPLE SUFFERING FROM PHYSICAL DISABILITY RELATED TO NTDs WHO RECEIVE REHABILITATION SUPPORT

COMMENT

Overall, most of the 17 main NTDs can lead directly to impairments: trachoma and onchocerciasis can cause blindness, while leprosy, chikungunya, yaws, lymphatic filariasis, Buruli ulcer, Chagas disease and African trypanosomiasis can lead to physical impairments. Venomous snakebites can result in physical deformity and impairment. NTDs can also cause impairments indirectly.

CHW TASK

As essential health educators and promoters in communities, addressing cultural concepts and beliefs around disability in the local community may be stigmatizing, hindering health seeking of rehabilitation support.

CHW DATA POINTS TO COLLECT

- Number of people suffering from physical disability related to NTDs who receive rehabilitation support.
- Number of people suffering from physical disability related to NTDs.

NUMERATOR

Number of people suffering from physical disability related to NTDs who receive rehabilitation support.

DENOMINATOR

Number of people suffering from physical disability related to NTDs.

DISAGGREGATION

Basic

- Age group ((0–5, 5–9, 10–14, 15–19, 20+)
- Gender (male, female, transgender)
- NTD

Advanced

- Residential status (resident/migrant)

MATURITY LEVEL

C.

FREQUENCY

Data to be reported on monthly, quarterly or yearly basis.

ALIGNMENT

SDG: 3.3: By 2030, end the epidemics of AIDS, tuberculosis, malaria and NTDs and combat hepatitis, waterborne diseases and other communicable diseases *(1)*

WHO NTD Roadmap 2011–2020 *(2)*

WHO NTD Roadmap 2021–2030 *(3)*

REFERENCES

1. Sustainable Development Goals. SDG indicators metadata repository. In: United Nations Statistics Division [website] (https://unstats.un.org/sdgs/metadata/, accessed 31 August 2020).
2. Accelerating work to overcome the global impact of neglected tropical diseases: a roadmap for implementation. Geneva: World Health Organization; 2012 (https://www.who.int/neglected_diseases/NTD_RoadMap_2012_Fullversion.pdf, accessed 31 August 2020).
3. Ending the neglect to attain the Sustainable Development Goals: a road map for neglected tropical diseases 2021–2030. Geneva: World Health Organization; 2020 (https://www.who.int/neglected_diseases/NTD_RoadMap_2012_Fullversion.pdf, accessed 31 August 2020).

149. NUMBER (AND PROPORTION) OF CASES WHO RECEIVED INSTRUCTIONS FOR SELF-CARE FOR RELEVANT NTDs

COMMENT

Self-care is defined as provision of and support for self-care packages (e.g. bandaging, foot hygiene, eye care), and training for patients whose disease involves a component of self-care for morbidity management.

This indicator is relevant to several NTDs (Buruli ulcer, cutaneous leishmaniasis, guinea worm, leprosy, lymphatic filariasis, mycetoma, scabies, schistosomiasis, trachoma, yaws) including animal bites (dogs and snakebites).

CHW TASK

As essential educators on self-management of NTD-derived wounds and gross morbidity, especially for chronic conditions, CHWs will ensure NTD cases are following self-care instructions given by the health-care worker at the health facilities.

CHW DATA POINTS TO COLLECT

- Number of NTD cases who received instructions for self-care for relevant NTDs.
- Number of NTD cases relevant for self-care.

NUMERATOR

Number of NTD cases who received instructions for self-care for relevant NTDs.

DENOMINATOR

Number of NTD cases relevant for self-care.

DISAGGREGATION

Basic

- Age group ((0–5, 5–9, 10–14, 15–19, 20+)
- Gender (male, female, transgender)
- NTD

Advanced

- Residential status (resident/migrant)

MATURITY LEVEL

B.

FREQUENCY

Data to be reported on monthly, quarterly or yearly basis.

ALIGNMENT

SDG: 3.3: By 2030, end the epidemics of AIDS, tuberculosis, malaria and NTDs and combat hepatitis, waterborne diseases and other communicable diseases *(1)*

WHO NTD Roadmap 2011–2020 *(2)*

WHO NTD Roadmap 2021–2030 *(3)*

REFERENCES

1. Sustainable Development Goals. SDG indicators metadata repository. In: United Nations Statistics Division [website] (https://unstats.un.org/sdgs/metadata/, accessed 31 August 2020).
2. Accelerating work to overcome the global impact of neglected tropical diseases: a roadmap for implementation. Geneva: World Health Organization; 2012 (https://www.who.int/neglected_diseases/NTD_RoadMap_2012_Fullversion.pdf, accessed 31 August 2020).
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150. PROPORTION OF TARGETED HOUSES COVERED BY DOMICILIARY VECTOR REDUCTION MEASURES

COMMENT

Non-insecticide vector reduction measures, including environmental manipulation (to remove breeding sites) and prevention of contact between human and vectors (e.g. bednets distribution) is a key vector control intervention for several vector-borne NTDs and can be performed by CHWs or members of the community under the supervision of the CHWs.

This activity is particularly important in Chagas disease, dengue and schistosomiasis control, and should be performed at the best moment considering vector life cycle and seasonality. This activity aims at reducing the breeding sites of mosquitoes and the infestation/colonization of Chagas disease vectors in and around houses.

CHW TASK

- House-to-house visit to perform environmental management activities in the context of integrated vector management and to empower women and children to conduct these activities regularly.
- For Aedes spp., environmental manipulation consists in the removal or destruction of larval and pupal habitats by partially or largely community-led campaigns. This activity is effective in reducing pupal and larval densities, with no obvious advantages between the different methods.
- For Chagas disease, vector reduction measures may consist in house improvements and house cleanliness, along with bednets distribution, to prevent vector infestation.

CHW DATA POINTS TO COLLECT

- Number of households where some domiciliary vector reduction measures were implemented.
- Number of households targeted.

NUMERATOR

Number of houses where some domiciliary vector reduction measures were implemented.

DENOMINATOR

Number of houses targeted for domiciliary vector reduction measures.

DISAGGREGATION

Basic

- Targeted vector

Advanced

None.

MATURITY LEVEL

A.

FREQUENCY

At least once a year (consider seasonality). For dengue, reporting should be weekly before and during dengue season of respective areas.

ALIGNMENT

SDG: 3.3: By 2030, end the epidemics of AIDS, tuberculosis, malaria and neglected tropical diseases and combat hepatitis, water-borne diseases and other communicable diseases *(1)*

REFERENCES

1. Sustainable Development Goals. SDG indicators metadata repository. In: United Nations Statistics Division [website] (https://unstats.un.org/sdgs/metadata/, accessed 31 August 2020).

Other

Accelerating work to overcome the global impact of neglected tropical diseases: a roadmap for implementation. Geneva: World Health Organization; 2012 (https://www.who.int/neglected_diseases/NTD_RoadMap_2012_Fullversion.pdf, accessed 31 August 2020).

Ending the neglect to attain the Sustainable Development Goals: a road map for neglected tropical diseases 2021–2030. Geneva: World Health Organization; 2020 (https://www.who.int/neglected_diseases/NTD_RoadMap_2012_Fullversion.pdf, accessed 31 August 2020).

151. NUMBER OF SURFACE WATER BODIES ENUMERATED AND MAPPED

COMMENT

Surface water is any body of water above ground, including streams, rivers, lakes, wetlands, reservoirs and creeks. Surface water bodies may represent at-risk breeding sites for vectors. Surface water bodies could be perennial (or permanent, i.e. surface water that persists throughout the year; e.g. swamps, lakes, river), ephemeral (or semipermanent or seasonal, i.e. exist only part of the year; e.g. creeks, lagoons, ponds, waterholes) and man-made (infrastructure human assembled; e.g. dams, constructed wetlands).

As part of integrated vector control management, CHWs should be in charge of regularly enumerating and mapping surface water bodies in their catchment area.

CHWs can either perform this task themselves or empower members of the community in performing this task.

This activity is particularly important in the context of guinea worm/dracunculiasis and schistosomiasis.

CHW TASK

Mapping and enumeration of surface water bodies; empowerment of women and children to perform this task.

CHW DATA POINTS TO COLLECT

Number and location of surface water bodies.

NUMERATOR

Number of surface water bodies enumerated and mapped.

DENOMINATOR

None.

DISAGGREGATION

Basic

- Geographic area

Advanced

None.

MATURITY LEVEL

A.

FREQUENCY

At least once a year (consider seasonality).

ALIGNMENT

SDG: 3.3: By 2030, end the epidemics of AIDS, tuberculosis, malaria and NTDs and combat hepatitis, waterborne diseases and other communicable diseases *(1)*

WHO NTD Roadmap 2011–2020 *(2)*

WHO NTD Roadmap 2021–2030 *(3)*

REFERENCES

1. Sustainable Development Goals. SDG indicators metadata repository. In: United Nations Statistics Division [website] (https://unstats.un.org/sdgs/metadata/, accessed 31 August 2020).
2. Accelerating work to overcome the global impact of neglected tropical diseases: a roadmap for implementation. Geneva: World Health Organization; 2012 (https://www.who.int/neglected_diseases/NTD_RoadMap_2012_Fullversion.pdf, accessed 31 August 2020).
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152. PROPORTION OF HOUSEHOLDS WITH ALL WATER STORAGE CONTAINERS COVERED AND PROTECTED

COMMENT

Water storage containers may represent at-risk breeding sites for vectors. Water-filled containers can be found inside the house (e.g. drums, jar, bucket) and in surrounding areas of dwellings (e.g. overhead tanks, rainwater harvesting tanks, non-used bottles, discarded waste, tires, etc., which hold water). Communities should be trained in covering and protecting all water storage containers in order to reduce the vector population and therefore the risk of vector-borne NTD transmission.

CHWs are key actors for behavioural change in the community and should regularly assess whether households are taking the recommended measures to prevent breeding sites.

This activity is particularly important in the context of dengue and other arboviral NTDs.

CHW TASK

House-to-house visits to identify uncovered and unprotected water storage containers and remind household members about good vector management practices.

CHW DATA POINTS TO COLLECT

- Number of water storage containers observed in the household.
- Number of water storage containers covered and protected in the household.
- Identification of households with at least one water storage container uncovered or unprotected.

NUMERATOR

Number of households with all containers covered and protected with lids.

DENOMINATOR

Number of households visited in the catchment area.

DISAGGREGATION

Basic

- Targeted vector

Advanced

None.

MATURITY LEVEL

A.

FREQUENCY

At least once a year (consider seasonality).

ALIGNMENT

SDG: 3.3: By 2030, end the epidemics of AIDS, tuberculosis, malaria and NTDs and combat hepatitis, waterborne diseases and other communicable diseases *(1)*

WHO NTD Roadmap 2011–2020 *(2)*

WHO NTD Roadmap 2021–2030 *(3)*

REFERENCES

1. Sustainable Development Goals. SDG indicators metadata repository. In: United Nations Statistics Division [website] (https://unstats.un.org/sdgs/metadata/, accessed 31 August 2020).
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153. NUMBER/PROPORTION OF HOUSEHOLDS REACHED WITH HEALTH PROMOTION MESSAGES ABOUT THE IMPACTS OF VIOLENCE AGAINST WOMEN AND WHERE TO SEEK HELP

COMMENT

CHWs should check if households were reached with health promotion messages about the impacts of violence against women and where to seek help.

WHO's Intimate Partner Violence website *(1)* offers many resources (guidelines, media and advocacy material) as well as a pocket guide (https://gbvguidelines.org/en/pocketguide/) *(2)*.

CHW TASK

Map households reached with health promotion messages about the impacts of violence against women and where to seek help.

CHW DATA POINTS TO COLLECT

Number of households reached with health promotion messages about the impacts of violence against women and where to seek help.

NUMERATOR

Number of households reached with health promotion messages about the impacts of violence against women and where to seek help.

DENOMINATOR

Number of households in the catchment area.

DISAGGREGATION

Basic

- Geographic area

Advanced

- Socioeconomic status (wealth quintile)
- Ethnicity (including indigenous status)

MATURITY LEVEL

B.

FREQUENCY

At least once a year.

ALIGNMENT

None.

REFERENCES

1. Intimate partner and sexual violence (violence against women). In: World Health Organization [website] (https://www.who.int/violence_injury_prevention/violence/sexual/en/, accessed 31 August 2020).
2. Inter-Agency Standing Committee. How to support survivors of gender-based violence when a GBV actor is not available in your area. Pocket guide. In: GBV Guidelines [website] (https://gbvguidelines.org/en/pocketguide/, accessed 31 August 2020).

Other

Caring for women subjected to violence: a WHO curriculum for training health-care providers. Geneva: World Health Organization; 2020 (https://www.who.int/reproductivehealth/publications/caring-for-women-subject-to-violence/en/, accessed 31 August 2020).

154. NUMBER OF REFERRALS MADE TO HEALTH OR OTHER ESSENTIAL SERVICES FOR WOMEN AND GIRLS WHO DISCLOSE INTIMATE PARTNER VIOLENCE OR SEXUAL VIOLENCE

COMMENT

Clear and systematic protocols should include clear linkages and referrals with other sectors such as social welfare, shelters and the justice sector as per national standards and inter-agency protocols. CHWs should receive training, support and supervision on the guiding principles for referral of women and girls who disclose intimate partner violence or sexual violence, and whether, when, to whom and how to refer.

WHO's Intimate Partner Violence website *(1)* offers many resources (guidelines, media and advocacy material) as well as a pocket guide (https://gbvguidelines.org/en/pocketguide/) *(2)*.

CHW TASK

Referral to health or other essential services for women and girls who disclose intimate partner violence or sexual violence.

CHW DATA POINTS TO COLLECT

Number of referrals made to health or other essential services for women and girls who disclose intimate partner violence or sexual violence.

NUMERATOR

Number of referrals made to health or other essential services for women and girls who disclose intimate partner violence or sexual violence.

DENOMINATOR

None.

DISAGGREGATION

Basic

- Type of services: health facility, psychological support/ counselling, legal, shelter, etc.
- Geographic area
- Age

Advanced

- Socioeconomic status (wealth quintile)
- Ethnicity (including indigenous status)

MATURITY LEVEL

A.

FREQUENCY

Monthly.

ALIGNMENT

None.

REFERENCES

1. Intimate partner and sexual violence (violence against women). In: World Health Organization [website] (https://www.who.int/violence_injury_prevention/violence/sexual/en/, accessed 31 August 2020).
2. Inter-Agency Standing Committee. How to support survivors of gender-based violence when a GBV actor is not available in your area. Pocket guide. In: GBV Guidelines [website] (https://gbvguidelines.org/en/pocketguide/, accessed 31 August 2020).

Other

Caring for women subjected to violence: a WHO curriculum for training health-care providers. Geneva: World Health Organization; 2020 (https://www.who.int/reproductivehealth/publications/caring-for-women-subject-to-violence/en/, accessed 31 August 2020).

155. NUMBER/PROPORTION OF GIRLS UNDER 15 YEARS OLD WHO HAVE UNDERGONE FEMALE GENITAL MUTILATION (FGM) OR ARE AT RISK OF FGM

COMMENT

Female genital mutilation (FGM) refers to all procedures involving partial or total removal of the external female genitalia or other injury to the female genital organs for non-medical reasons. FGM has no known health benefits and can lead to health consequences in the short term and over the life-course. FGM is recognized internationally as a violation of the human rights of girls and women. It reflects deep-rooted inequality between the sexes, and constitutes an extreme form of discrimination against women. It is nearly always carried out on minors and is a violation of the rights of children. The practice also violates a person's rights to health, security and physical integrity; the right to be free from torture and cruel, inhuman or degrading treatment; and the right to life when the procedure results in death.

Prevalence data on FGM are captured in household surveys using a standardized module in the Demographic and Health Surveys and the Multiple Indicator Cluster Surveys in over 30 countries. The purpose of CHWs collecting data on FGM would be to identify at-risk households for targeted prevention efforts and to ensure that health complications due to FGM are properly managed. **Households with girls under age 15 in which the mother or older sisters have already undergone FGM are at high risk of undergoing FGM**.

CHW TASK

- Identification of households where girls are at risk of undergoing FGM.
- Identification of households where women and girls who have undergone the practice are at risk of and/or are suffering from health complications.

CHW DATA POINTS TO COLLECT

Number of girls under 15 years old: Those who have undergone FGM and those who have NOT undergone FGM.

NUMERATOR

N1: Number of girls under 15 years old who have undergone FGM.

N2: Number of girls under 15 years old who have NOT undergone FGM.

DENOMINATOR

Number of girls under 15 years old.

DISAGGREGATION

Basic

- Geographic area
- Age (0–4, 5–9, 10–14)

Advanced

- FGM type
- Socioeconomic status
- Education level

MATURITY LEVEL

B.

FREQUENCY

At least once a year.

DIGITALIZATION

Disaggregation can be automatic for geographic area, education level and socioeconomic status, if the information is already collected with a personal identifier.

ALIGNMENT

SDG: 5.3.2: Proportion of girls and women aged 15–49 who have undergone FGM/cutting *(1)*

WHO 100 indicators: Prevalence of female genital mutilation/cutting *(2)*

Global Strategy for Women's, Children's and Adolescents' Health: Proportion of girls and women aged 15–49 years who have undergone female genital mutilation/cutting (FMG/C) (%) *(3)*

HDC facility guidance: RMNCAH: Female genital mutilation *(4)*

REFERENCES

1. Sustainable Development Goals. SDG indicators metadata repository. In: United Nations Statistics Division [website] (https://unstats.un.org/sdgs/metadata/, accessed 31 August 2020).
2. 2018 global reference list of 100 core health indicators (plus health-related SDGs). Geneva: WHO; 2018 (https://apps.who.int/iris/bitstream/handle/10665/259951/WHO-HIS-IER-GPM-2018.1-eng.pdf, accessed 31 August 2020).
3. Global Health Observatory (GHO) Data [online database]. Global Strategy for Women's, Children's and Adolescents' Health (2016–2030): Data portal. In: World Health Organization [website] (https://www.who.int/gho/publications/gswcah_portal/en/, accessed 31 August 2020).
4. Analysis and use of health facility data: guidance for RMNCAH programme managers. Working Document. October 2019. Geneva: World Health Organization; 2019 (https://www.who.int/healthinfo/FacilityAnalysisGuidance_RMNCAH.pdf, accessed 31 August 2020).

Other

Care of women and girls with female genital mutilation: a clinical handbook. Geneva: World Health Organization; 2018 (https://www.who.int/reproductivehealth/publications/health-care-girls-women-living-with-FGM/en/, accessed 31 August 2020).

WHO guidelines on the management of health complications from female genital mutilation. Geneva: World Health Organization; 2016 (https://www.who.int/reproductivehealth/topics/fgm/management-health-complications-fgm/en/, accessed 31 August 2020).

Eliminating female genital mutilation: an interagency statement – OHCHR, UNAIDS, UNDP, UNECA, UNESCO, UNFPA, UNHCR, UNICEF, UNIFEM, WHO. Geneva: World Health Organization; 2008 https://www.who.int/reproductive-health/publications/fgm/9789241596442/en/, accessed 31 August 2020).

156. NUMBER/PROPORTION OF HOUSEHOLDS WITH CHILDREN WHERE CHW RAISED AWARENESS OF POSITIVE PARENTING

COMMENT

CHWs should receive training, support and supervision on how best to raise awareness of positive parenting at household level.

CHW TASK

Prevention of violence and promotion of positive parenting practices.

CHW DATA POINTS TO COLLECT

Number of households where CHW raised awareness of positive parenting.

NUMERATOR

Number of households where CHW raised awareness of positive parenting.

DENOMINATOR

Number of households in the catchment area.

DISAGGREGATION

Basic

- Geographic area

Advanced

- Socioeconomic status (wealth quintile)
- Ethnicity (including indigenous status)
- Education level of caregiver

MATURITY LEVEL

B.

FREQUENCY

At least once a year.

ALIGNMENT

None.

REFERENCES

None.

157. NUMBER OF HOUSEHOLDS WHERE CHW PROVIDED REFERRALS TO FAMILY SERVICES

COMMENT

Clear and systematic protocols should include clear linkages and referrals with other sectors such as social welfare, shelters and the justice sector as per national standards and inter-agency protocols. CHWs should receive training, support and supervision on the guiding principles for referral, and whether, when, to whom and how to refer.

CHW TASK

Referring households with children at risk of violence to family services (domestic violence, mental health, substance abuse, disability, etc.).

CHW DATA POINTS TO COLLECT

Number of households where CHW provided referrals to family services.

NUMERATOR

Number of households where CHW provided referrals to family services.

DENOMINATOR

Number of households in the catchment area.

DISAGGREGATION

Basic

- Geographic area
- Main reason for referral: (a) child maltreatment, (b) mental health status of caregiver, (c) alcohol use by caregiver, (c) drug use by caregiver, (d) other (please specify:…)

Advanced

- Socioeconomic status (wealth quintile)
- Ethnicity (including indigenous status)
- Education level of caregiver

MATURITY LEVEL

A.

FREQUENCY

Monthly.

ALIGNMENT

None.

REFERENCES

None.

158. NUMBER OF ADULT DEATHS

COMMENT

Countries may wish to further disaggregate by causes of death if they estimate that CHWs can identify them by verbal autopsy. Specific indicators on causes of death linked to SDGs are listed in the CRVS module.

CHW TASK

- Death notification.
- Identification of an adult death.

CHW DATA POINTS TO COLLECT

Number of new adult deaths in the reporting period.

NUMERATOR

Number of new adult deaths in the reporting period.

DENOMINATOR

None.

DISAGGREGATION

Basic

- Geographic area
- Place of occurrence and place of usual residence
- Gender (male, female, transgender)
- Age (20–24, 25–29, 30–34, 35–39, 40–44, 45–49, 50–54, 55–59, 60–64, 65–69, 70–74, 75–79, 80–84, 85+)

Advanced

- Ethnic group
- Migratory status
- Socioeconomic status (wealth quintile)
- Main education level

MATURITY LEVEL

A.

FREQUENCY

Monthly if reporting based on consultations.
Less frequently (at least once a year) if reported by household assessment.

DIGITALIZATION

Interoperability with death notification services would allow better case review.

Disaggregation can be automatic, especially for age, sex, geographic area, HIV status, maternal or main caregiver's education level, ethnic group, socioeconomic status, if feasible.

ALIGNMENT

WHO 100 indicators: Adult mortality rate between 15 and 60 years of age *(1)*

REFERENCES

1. 2018 global reference list of 100 core health indicators (plus health-related SDGs). Geneva: WHO; 2018 (https://apps.who.int/iris/bitstream/handle/10665/259951/WHO-HIS-IER-GPM-2018.1-eng.pdf, accessed 31 August 2020).

159. NUMBER OF DEATHS DUE TO ROAD TRAFFIC CRASHES

COMMENT

Road traffic injuries are the leading cause of death for children and young adults aged 5–29 years.* A traffic accident is any vehicle accident occurring on the public highway or street. Deaths involve drivers and occupants of motor or non-motor vehicles, riders of animal-drawn vehicles, pedal cyclists, motorcyclists and pedestrians.

CHW TASK

Reporting of road traffic deaths.

CHW DATA POINTS TO COLLECT

Number of deaths due to road traffic crashes.

NUMERATOR

Number of deaths due to road traffic crashes.

DENOMINATOR

None.

DISAGGREGATION

Basic

- Age (age groups 10–14, 15–17, 18–19 should be considered for adolescents)
- Sex
- Geographic area

Advanced

- Socioeconomic status (wealth quintile)
- Type of road user: Pedestrian, drivers, occupant/passenger, pillion riders
- Type of vehicle: bicycle, 2 or 3-wheeled vehicle, 4-wheeled cars and light vehicles, heavy truck, bus, other
- Ethnic group

MATURITY LEVEL

C.

Longitudinal follow-up is necessary to avoid double counting.

Interoperability of records between facility, police and ambulance services are necessary for confirmation of the death and to avoid double counting.

FREQUENCY

Monthly.

DIGITALIZATION

Interoperability with death notification and police or ambulance services would allow better case review.

Disaggregation can be automatic, especially for age, sex, geographic area, socioeconomic status, if feasible.

ALIGNMENT

SDG: 3.6.1: Death rate due to road traffic injuries *(1)*

WHO 100 indicators: Death rate due to road traffic injuries *(2)*

REFERENCES

1. Sustainable Development Goals. SDG indicators metadata repository. In: United Nations Statistics Division [website] (https://unstats.un.org/sdgs/metadata/, accessed 31 August 2020).
2. 2018 global reference list of 100 core health indicators (plus health-related SDGs). Geneva: WHO; 2018 (https://apps.who.int/iris/bitstream/handle/10665/259951/WHO-HIS-IER-GPM-2018.1-eng.pdf, accessed 31 August 2020).

* See: https://www.who.int/news-room/fact-sheets/detail/road-traffic-injuries.

160. NUMBER OF DEATHS DUE TO DROWNING

CHW TASK

- Reporting of deaths due to drowning.
- Include drowning and submersion in lake, open sea, river, stream, quenching tank, reservoir, swimming pool, bathtub.

CHW DATA POINTS TO COLLECT

Number of deaths due to drowning.

NUMERATOR

Number of deaths due to drowning.

DENOMINATOR

None.

DISAGGREGATION

Basic

- Age (0–4, 5–9, 10–14, 15–19, 20–24, 25–29, 30–34, 35–39, 40–44, 45–49, 50–54, 55–59, 60–64, 65–69, 70–74, 75–79, 80+)
- Sex
- Geographic area

Advanced

- Socioeconomic status (wealth quintile)
- Education level
- Sea, pool, lake, river, pond, ditch, container, other
- Water transportation, flood disaster
- Ethnic group
- Migratory status

MATURITY LEVEL

C.

Interoperability of records between facility, police and ambulance services are necessary for confirmation of the death and to avoid double counting.

FREQUENCY

Monthly if reporting based on consultations.
Less frequently (at least once a year) if reported by household assessment.

DIGITALIZATION

Interoperability with death notification and police services would allow better case review.

Disaggregation can be automatic, especially for age, sex, geographic area, education level and socioeconomic status, if feasible.

ALIGNMENT

None.

REFERENCES

None.

161. NUMBER/PROPORTION OF LIVE BIRTHS HAPPENING IN REPORTING PERIOD THAT WERE NOT REGISTERED, FOR WHICH NOTIFICATION WAS SUBMITTED BY CHW TO LOCAL AUTHORITIES

COMMENT

The maximum registration period for a birth will depend on each country's civil registration system.

CHW TASK

Track live births that are not registered, and submit notification to local authorities.

DENOMINATOR

Number of live births happening in reporting period that were not registered.

CHW DATA POINTS TO COLLECT

- Number of live births happening in reporting period that were not registered, for which notification was submitted by CHW to local authorities in the reporting period.
- Number of live births happening in reporting period that were not registered.

NUMERATOR

Number of live births happening in reporting period that were not registered, for which notification was submitted by CHW to local authorities in the reporting period.

DISAGGREGATION

Basic

- Age (months)
- Sex (male, female)
- Geographic area

Advanced

- Socioeconomic status (wealth quintile)
- Education level

MATURITY LEVEL

A.

FREQUENCY

Monthly.

DIGITALIZATION

Interoperability with birth notification services would allow feedback.

Disaggregation can be automatic, especially for age, sex, geographic area, education level and socioeconomic status, if feasible.

ALIGNMENT

SDG: 17.19.2: Proportion of countries that (a) have conducted at least one population and housing census in the last 10 years; and (b) have achieved 100% birth registration and 80% death registration; 16.9.1: Proportion of children under 5 years of age whose births have been registered with a civil authority, by age *(1)*

WHO 100 indicators: Birth registration *(2)*

Global Strategy for Women's, Children's and Adolescents' Health: Proportion civil registration coverage of births *(3)*

HDC facility guidance: RMNCAH: Notification for birth registration *(4)*

REFERENCES

1. Sustainable Development Goals. SDG indicators metadata repository. In: United Nations Statistics Division [website] (https://unstats.un.org/sdgs/metadata/, accessed 31 August 2020).
2. 2018 global reference list of 100 core health indicators (plus health-related SDGs). Geneva: WHO; 2018 (https://apps.who.int/iris/bitstream/handle/10665/259951/WHO-HIS-IER-GPM-2018.1-eng.pdf, accessed 31 August 2020).
3. Global Health Observatory (GHO) Data [online database]. Global Strategy for Women's, Children's and Adolescents' Health (2016–2030): Data portal. In: World Health Organization [website] (https://www.who.int/gho/publications/gswcah_portal/en/, accessed 31 August 2020).
4. Analysis and use of health facility data: guidance for RMNCAH programme managers. Working Document. October 2019. Geneva: World Health Organization; 2019 (https://www.who.int/healthinfo/FacilityAnalysisGuidance_RMNCAH.pdf, accessed 31 August 2020).

162. NUMBER/PROPORTION OF DEATHS HAPPENING IN THE REPORTING PERIOD THAT WERE NOT REGISTERED, FOR WHICH NOTIFICATION WAS SUBMITTED BY CHW TO LOCAL AUTHORITIES

COMMENT

The maximum registration period for a death will depend on each country's civil registration system.

CHW TASK

Track unregistered deaths and notify local authorities.

CHW DATA POINTS TO COLLECT

- Number of deaths happening in the reporting period that were not registered, for which notification was submitted by CHW to local authorities.
- Number of deaths happening in the reporting period that were not registered.

NUMERATOR

Number of deaths happening in the reporting period that were not registered, for which notification was submitted by CHW to local authorities.

DENOMINATOR

Number of deaths happening in the reporting period that were not registered.

DISAGGREGATION

Basic

- Age
- Place of occurrence
- Facility, community
- Sex
- Geographic area

Advanced

- Socioeconomic status (wealth quintile)
- Education level
- Ethnic group
- Migratory status

MATURITY LEVEL

A.

FREQUENCY

Monthly.

DIGITALIZATION

Interoperability with death notification services would allow feedback.

Disaggregation can be automatic, especially for age, sex, ethnic group, geographic area, education level and socioeconomic status, if feasible.

ALIGNMENT

SDG: 17.19.2: Proportion of countries that (a) have conducted at least one population and housing census in the last 10 years; and (b) have achieved 100% birth registration and 80% death registration *(1)*

WHO 100 indicators: Death registration *(2)*

REFERENCES

1. Sustainable Development Goals. SDG indicators metadata repository. In: United Nations Statistics Division [website] (https://unstats.un.org/sdgs/metadata/, accessed 31 August 2020).
2. 2018 global reference list of 100 core health indicators (plus health-related SDGs). Geneva: WHO; 2018 (https://apps.who.int/iris/bitstream/handle/10665/259951/WHO-HIS-IER-GPM-2018.1-eng.pdf, accessed 31 August 2020).

163. NUMBER/PROPORTION OF CHILDREN UNDER-FIVE YEAR OLD WHOSE BIRTHS ARE REGISTERED WITH THE CIVIL AUTHORITY

COMMENT

The right to birth registration, especially to a birth certificate, is a fundamental means of safeguarding a person's rights for the entirety of their life.

CHW TASK

Track children under the age of 5 having full birth registration.

CHW DATA POINTS TO COLLECT

Number of children under the age of 5 whose births are registered with the civil authority.

NUMERATOR

Number of children under the age of 5 whose births are registered with the civil authority.

DENOMINATOR

Number of children under the age of 5 screened.

DISAGGREGATION

Basic

- Geographic area
- Age: <1; 1-4
- Sex (male, female)
- Possession of birth certificate: yes, no

Advanced

- Socioeconomic status (wealth quintile)
- Main education level
- Ethnic group
- Migratory status

MATURITY LEVEL

B.

Longitudinal tracking is necessary to avoid double counting.

FREQUENCY

At least once a year.

DIGITALIZATION

Disaggregation can be automatic, especially for ethnic group, geographic area, education level and socioeconomic status, if feasible.

ALIGNMENT

SDG: 16.9.1: Proportion of children under 5 years of age whose births have been registered with a civil authority *(1)*

WHO 100 indicators: Birth registration *(2)*

REFERENCES

1. Sustainable Development Goals. SDG indicators metadata repository. In: United Nations Statistics Division [website] (https://unstats.un.org/sdgs/metadata/, accessed 31 August 2020).
2. 2018 global reference list of 100 core health indicators (plus health-related SDGs). Geneva: WHO; 2018 (https://apps.who.int/iris/bitstream/handle/10665/259951/WHO-HIS-IER-GPM-2018.1-eng.pdf, accessed 31 August 2020).

164. NUMBER/PROPORTION OF DEATHS THAT WERE REGISTERED IN A TIMELY MANNER OVER THE REPORTING PERIOD

CHW TASK

Map households with deaths reported to civil registration.

CHW DATA POINTS TO COLLECT

Number of households with a death certificate for deaths reported during the reporting period.

NUMERATOR

Number of households with a death certificate for deaths reported during the reporting period.

DENOMINATOR

Number of households.

DISAGGREGATION

Basic

- Geographic area

Advanced

- Socioeconomic status (wealth quintile)
- Main education level
- Ethnic group
- Migratory status

MATURITY LEVEL

B.

Longitudinal tracking is necessary to avoid double counting.

FREQUENCY

At least once a year.

DIGITALIZATION

Disaggregation can be automatic, especially the ethnic group, geographic area, education level and socioeconomic status, if feasible.

ALIGNMENT

SDG: 17.19.2: Proportion of countries that (a) have conducted at least one population and housing census in the last 10 years; and (b) have achieved 100% birth registration and 80% death registration *(1)*

WHO 100 indicators: Death registration *(2)*

REFERENCES

1. Sustainable Development Goals. SDG indicators metadata repository. In: United Nations Statistics Division [website] (https://unstats.un.org/sdgs/metadata/, accessed 31 August 2020).
2. 2018 global reference list of 100 core health indicators (plus health-related SDGs). Geneva: WHO; 2018 (https://apps.who.int/iris/bitstream/handle/10665/259951/WHO-HIS-IER-GPM-2018.1-eng.pdf, accessed 31 August 2020).

165. PROPORTION OF CURRENT TOBACCO USERS

COMMENT

This indicator for the age 15–18 overlaps with the indicator for tobacco use in adolescents, so they should be articulated together.

Confidentiality is essential, especially for women. Questions on tobacco use should be asked individually in a confidential setting, and the information not shared. Please refer to section 7.5.4 on confidentiality in the main text of this guidance.

CHW TASK

Community interventions to stop tobacco use and follow up on consumption.

NUMERATOR

Number of current tobacco users aged 15 years and over. "Current users" includes both daily and non-daily users of smoked or smokeless tobacco in the previous 30 days.

CHW DATA POINTS TO COLLECT

Number of current tobacco users aged 15 years and over.

DENOMINATOR

Number of people 15 years old and over.

DISAGGREGATION

Basic

- Geographic area
- Age
- Sex
- Tobacco use (smoked and/or smokeless tobacco) (daily or non-daily)

Advanced

- Socioeconomic status (wealth quintile)
- Education level
- Smoked tobacco products: Cigarettes, cigarillos, cigars, cheroots, bidis, pipes, shisha (water pipes), roll-your-own tobacco, kretek and any other form of tobacco that is consumed by smoking
- Smokeless tobacco product: Moist snuff, creamy snuff, dry snuff, plug, dissolvables, gul, loose leaf, red tooth powder, snus, chimo, gutkha, khaini, gudakhu, zarda, quiwam, dohra, tuibur, nasway, naas, naswar, shammah, toombak, paan (betel quid with tobacco), iq'mik, mishri, tapkeer, tombol and any other tobacco product that consumed by sniffing, holding in the mouth or chewing

MATURITY LEVEL

B.

Longitudinal follow-up is necessary.

FREQUENCY

Monthly if reporting based on consultations.
Less frequently (at least once a year) if reported by household assessment.

DIGITALIZATION

Disaggregation can be automatic, especially for age, geographic area, sex, education level and socioeconomic status.

The type of tobacco use should be presented in a preset menu.

ALIGNMENT

SDG: 3.a.1: Age-standardized prevalence of current tobacco use among persons aged 15 years and older *(1)*

WHO 100 indicators: Tobacco use among persons aged 15+ years *(2)*

REFERENCES

1. Sustainable Development Goals. SDG indicators metadata repository. In: United Nations Statistics Division [website] (https://unstats.un.org/sdgs/metadata/, accessed 31 August 2020).
2. 2018 global reference list of 100 core health indicators (plus health-related SDGs). Geneva: WHO; 2018 (https://apps.who.int/iris/bitstream/handle/10665/259951/WHO-HIS-IER-GPM-2018.1-eng.pdf, accessed 31 August 2020).

166. INSUFFICIENT PHYSICAL ACTIVITY AMONG ADULTS

COMMENT

The *WHO Guidelines on global recommendations on physical activity for health (1)* recommend that:

- Adults aged 18–64 years should do at least 150 minutes of moderate-intensity aerobic physical activity throughout the week, or do at least 75 minutes of vigorous-intensity aerobic physical activity throughout the week, or an equivalent combination of moderate- and vigorous-intensity activity.
- Adults aged 65 years and above should do at least 150 minutes of moderate-intensity aerobic physical activity throughout the week, or do at least 75 minutes of vigorous-intensity aerobic physical activity throughout the week, or an equivalent combination of moderate- and vigorous-intensity activity.

The Global Physical Activity Questionnaire (GPAQ) *(2)* is the recommended WHO tool. CHWs should be trained to administer it, and it should take 5 minutes to complete. The supervisors can then extract the results.

WHO will be releasing updated guidelines late 2020, and the GPAQ should be updated in 2021.

CHW TASK

Recommendation and follow-up on physical activity.

CHW DATA POINTS TO COLLECT

Number of adults not meeting WHO recommendations on physical activity for health.

NUMERATOR

Number of adults not meeting WHO recommendations on physical activity for health.

DENOMINATOR

Number of adults in the catchment area.

DISAGGREGATION

Basic

- Geographic area
- Age
- Gender (male, female)

Advanced

- Education level
- Socioeconomic status (wealth quintile)

MATURITY LEVEL

B.

Longitudinal follow-up is necessary.

FREQUENCY

At least once a year.

DIGITALIZATION

Disaggregation can be automatic, especially for age, geographic area, gender, education level and socioeconomic status, if feasible.

The GPAQ should be presented in a preset menu.

ALIGNMENT

WHO 100 indicators: Insufficient physical activity in adults (Also: adolescents) *(3)*

REFERENCES

1. Global recommendations on physical activity for health. In: World Health Organization [website] (https://www.who.int/dietphysicalactivity/publications/9789241599979/en/, accessed 31 August 2020).
2. Global Physical Activity Questionnaire (GPAQ) Analysis Guide. Geneva: World Health Organization; n.d. (https://www.who.int/ncds/surveillance/steps/resources/GPAQ_Analysis_Guide.pdf, accessed 31 August 2020).
3. 2018 global reference list of 100 core health indicators (plus health-related SDGs). Geneva: WHO; 2018 (https://apps.who.int/iris/bitstream/handle/10665/259951/WHO-HIS-IER-GPM-2018.1-eng.pdf, accessed 31 August 2020).

Other

Global recommendations on physical activity for health. Geneva: World Health Organization; 2010 (https://www.who.int/dietphysicalactivity/factsheet_recommendations/en/, accessed 31 August 2020).

167. PROPORTION OF OVERWEIGHT AND OBESITY IN ADULTS

COMMENT

Height and weight measurement at the community level requires specific material, training and supervision that is not currently available and feasible in many settings.

Still, this indicator can be considered when feasible considering the growing importance of NCDs, especially in settings where overweight prevalence is a concern, there is confidence in the accuracy of weight and height measurement, and sufficient coverage and understanding of the child population measured for the results to be interpreted appropriately.

CHW TASK

Measurement of height and weight.

CHW DATA POINTS TO COLLECT

- Weight and height of adults.
- Number of adults who were measured.

NUMERATOR

Number of adults who are overweight (BMI 25.0–29.9) and obese (BMI ≥ 30.0).

DENOMINATOR

Number of adults who were measured.

DISAGGREGATION

Basic

- Geographic area
- Age (20–24, 25–29, 30–34, 35–39, 40–44, 45–49, 50–54, 55–59, 60–64, 65–69, 70–74, 75–79, 80+)
- Gender (male, female)

Advanced

- Socioeconomic status (wealth quintile)
- Education level
- Main caregiver's education level
- Severity (overweight, obese)

MATURITY LEVEL

B.

Longitudinal follow-up is necessary.

FREQUENCY

Monthly if reporting based on consultations.
Less frequently (at least once a year) if reported by household assessment.

DIGITALIZATION

BMI could be automatically calculated with feedback on results and severity.

Disaggregation can be automatic, especially for age, geographic area, sex, education level and socioeconomic status.

ALIGNMENT

WHO 100 indicators: Overweight and obesity in adults (Also: school-age children and adolescents) *(1)*

WHO NCD Global Monitoring Framework: Prevalence of overweight and obesity in adolescents *(2)*

REFERENCES

1. 2018 global reference list of 100 core health indicators (plus health-related SDGs). Geneva: WHO; 2018 (https://apps.who.int/iris/bitstream/handle/10665/259951/WHO-HIS-IER-GPM-2018.1-eng.pdf, accessed 31 August 2020).
2. NCD Global Monitoring Framework. In: World Health Organization [website] (https://www.who.int/nmh/global_monitoring_framework/en/, accessed 31 August 2020).

168. NUMBER/PROPORTION OF ASYMPTOMATIC ADULTS OLDER THAN 40 WITH A BMI ≥ 25 WHO HAVE RAISED BLOOD GLUCOSE/DIABETES

COMMENT

Fasting is preferred, but when not feasible, screening without fasting is an alternative. Journey from screening to referral, confirmation, results feedback and treatment should be clearly mapped, articulated, funded and integrated into the health system.

Raised blood glucose/diabetes is defined as fasting capillary glucose concentration ≥ 7.0 mmol/L (126 mg/dL) or on medication for raised blood glucose.

Other types of screening can be found – for example, https://www.who.int/publications/i/item/who-ucn-ncd-20.1 *(1)* – but seem less feasible to be conducted by CHWs.

CHW TASK

Screening for diabetes by measuring capillary fasting glucose.

DENOMINATOR

Number of asymptomatic adults older than 40 with a BMI ≥ 25 in the catchment area.

CHW DATA POINTS TO COLLECT

Number of asymptomatic adults older than 40 with a BMI ≥ 25 who have raised blood glucose/diabetes (defined as fasting capillary glucose concentration ≥ 7.0 mmol/L [126 mg/dL] measured by CHW or on medication for raised blood glucose).

NUMERATOR

Number of asymptomatic adults older than 40 with a BMI ≥ 25 who have raised blood glucose/diabetes (defined as fasting capillary glucose concentration ≥ 7.0 mmol/L [126 mg/dL] measured by CHW or on medication for raised blood glucose).

DISAGGREGATION

Basic

- Geographic area
- Age (40–44, 45–49, 50–54, 55–59, 60–64, 65–69, 70–74, 75–79, 80+)
- On medication for raised blood glucose

Advanced

- Referral
- Socioeconomic status (wealth quintile)
- BMI

MATURITY LEVEL

C.

Longitudinal follow-up is necessary, as well as interoperability of records between structures.

FREQUENCY

Monthly or at least once a year.

DIGITALIZATION

If people can be tracked with a unique identifier, the number of people identified can be automatically reported each month. Interoperability with the facility is also critical so data can be reconciled to avoid double counting.

Disaggregation can be automatic, especially for age, sex, geographic area, socioeconomic status, if feasible.

ALIGNMENT

WHO 100 indicators: Raised blood glucose/diabetes among adults *(2)*

WHO NCD Global Monitoring Framework: Age-standardized prevalence of raised blood glucose/diabetes among persons aged 18+ years *(3)*

REFERENCES

1. HEARTS-D: Diagnosis and management of type 2 diabetes. Geneva: World Health Organization; 2020 (https://www.who.int/publications/i/item/who-ucn-ncd-20.1, accessed 31 August 2020).
2. 2018 global reference list of 100 core health indicators (plus health-related SDGs). Geneva: WHO; 2018 (https://apps.who.int/iris/bitstream/handle/10665/259951/WHO-HIS-IER-GPM-2018.1-eng.pdf, accessed 31 August 2020).
3. NCD Global Monitoring Framework. In: World Health Organization [website] (https://www.who.int/nmh/global_monitoring_framework/en/, accessed 31 August 2020).

169. NUMBER/PROPORTION OF PEOPLE SUPPORTED FOR DRUG THERAPY AND COUNSELLED TO PREVENT HEART ATTACKS AND STROKE

COMMENT

Drug therapy is defined as taking medication for raised blood glucose/diabetes, raised total cholesterol, or raised blood pressure, or taking aspirin or statins to prevent or treat heart disease.

Counselling is defined as receiving advice from a doctor or other health worker to quit using tobacco or not start, reduce salt in diet, eat at least five servings of fruit and/or vegetables per day, reduce fat in diet, start or do more physical activity, maintain a healthy body weight or lose weight.

Where it is feasible, provided that CHWs are trained, the WHO/International Society of Hypertension (ISH) risk prediction charts *(1)* can be used to evaluate the 10-year cardiovascular risk of people.

CHW TASK

Follow-up, counselling (including glycaemic control) and therapy support for prevention of heart attacks and stroke.

CHW DATA POINTS TO COLLECT

Number of persons to whom heart attacks and stroke preventive and curative therapy support/follow-up was provided.

NUMERATOR

Number of persons to whom heart attacks and stroke preventive and curative therapy support/follow-up was provided.

DENOMINATOR

People 40 and older who either have an established cardiovascular disease (coronary heart disease, stroke, or other atherosclerotic disease), or who are smoking, have high blood pressure, high cholesterol, or diabetes.

Where training is feasible, CHWs can instead use the WHO/ISH Risk prediction charts for their WHO epidemiological subregion and include people who have a 10-year cardiovascular risk of 30% or higher.

DISAGGREGATION

Basic

- Age (40–44, 45–49, 50–54, 55–59, 60–64, 65–69, 70–74, 75–79, 80+)
- Sex
- Geographic area

Advanced

- Drug therapy: Medication for raised blood glucose/diabetes, raised total cholesterol, or raised blood pressure, or taking aspirin or statins to prevent or treat heart disease
- Socioeconomic status (wealth quintile)
- Education level
- Established cardiovascular disease (coronary heart disease, stroke or other atherosclerotic disease)
- Smoking, have high blood pressure, high cholesterol, and/or diabetes

MATURITY LEVEL

C.

Interoperability of records between facility and longitudinal follow-up are necessary.

FREQUENCY

Monthly.

DIGITALIZATION

Disaggregation can be automatic, especially for age, sex, geographic area, education level and socioeconomic status, blood pressure, smoking status, glycaemia, cholesterol level and therapy, especially if there is interoperability with facility data.

ALIGNMENT

WHO 100 indicators: Drug therapy and counselling to prevent heart attacks and stroke *(2)*

WHO NCD Global Monitoring Framework: Drug therapy and counselling to prevent heart attacks and stroke *(3)*

REFERENCES

1. World Health Organization/International Society of Hypertension (WH0/ISH) risk prediction charts for 14 WHO epidemiological sub-regions (charts in colour). Geneva: World Health Organization; 2014 (https://www.who.int/ncds/management/WHO_ISH_Risk_Prediction_Charts.pdf, accessed 31 August 2020).
2. 2018 global reference list of 100 core health indicators (plus health-related SDGs). Geneva: WHO; 2018 (https://apps.who.int/iris/bitstream/handle/10665/259951/WHO-HIS-IER-GPM-2018.1-eng.pdf, accessed 31 August 2020).
3. Noncommunicable diseases global monitoring framework: indicator definitions and specifications. Geneva: World Health Organization; 2014 (https://www.who.int/nmh/ncd-tools/indicators/GMF_Indicator_Definitions_FinalNOV2014.pdf, accessed 31 August 2020).

170. NUMBER/PROPORTION OF DRUG OVERDOSE DEATHS

COMMENT

The identification of drug overdose deaths can be done based on information received from household members or other potential witnesses or informants who knew the person by asking a simple question about the reason the death occurred.

CHW TASK

Identification of drug overdose deaths in the past 12 months.

CHW DATA POINTS TO COLLECT

Number of drug overdose deaths in the past 12 months.

NUMERATOR

Number of persons who died from drug overdose deaths in the past 12 months.

DENOMINATOR

Total number of adults and adolescents in the catchment area.

DISAGGREGATION

Basic

- Age (10–14, 15–19, 20–24, 25–29, 30–34, 35–39, 40–44, 45–49, 50–54, 55–59, 60–64, 65–69, 70–74, 75–79, 80+)
- Opioid, non-opioid, unknown
- Gender (male, female, transgender)
- Geographic area

Advanced

- Socioeconomic status (wealth quintile)
- Education level

MATURITY LEVEL

C.

FREQUENCY

At least once a year.

DIGITALIZATION

Disaggregation can be automatic, especially for age, geographic area, sex, education level and socioeconomic status, if feasible.

ALIGNMENT

SDG: 3.5: Strengthen the prevention and treatment of substance abuse, including narcotic drug abuse and harmful use of alcohol *(1)*

REFERENCES

1. Sustainable Development Goals. SDG indicators metadata repository. In: United Nations Statistics Division [website] (https://unstats.un.org/sdgs/metadata/, accessed 31 August 2020).

Other

World Drug Report 2020. Vienna: United Nations Office on Drugs and Crime; 2020 (https://wdr.unodc.org/wdr2020/, accessed 31 August 2020).

171. NUMBER OF PEOPLE WHO NEEDED CARE AND DID NOT GET IT IN THE LAST MONTH

COMMENT

WHO's definition of UHC is, "All people and communities receive the health services they need, without facing financial hardship." It is therefore critical to track whether people get the services they need, and if not, the main reason for lack of access to care.

CHW TASK

Review whether people can access care and if they do not, why.

CHW DATA POINTS TO COLLECT

Number of people who needed care and did not get it in the last month.

NUMERATOR

Number of people who needed care and did not get it in the last month.

DENOMINATOR

Total number of people in the catchment area.

DISAGGREGATION

Basic

- Age (0–4, 5–9, 10–14, 15–19, 20–24, 25–29, 30–34, 35–39, 40–44, 45–49, 50–54, 55–59, 60–64, 65–69, 70–74, 75–79, 80+)
- Gender (male, female)
- Specific condition (TB, HIV, NTD, etc.)
- Reasons: Cost/no health insurance, physical access/ transportation issue, service schedules, services not available, perceived lack of quality of services, perceived discrimination, confidentiality issue, lack of safety on the way, third person consent, house duties, lack of information, belief/religion, other
- Geographic area

Advanced

- TB key population (people who use drugs, miners, prisoners, health workers, indigenous persons, mobile and migrant populations, urban poor)
- HIV key populations (men who have sex with men, people who inject drugs, sex workers, transgender people)

MATURITY LEVEL

B.

Longitudinal follow-up is key.

FREQUENCY

At least once a year.

DIGITALIZATION

Disaggregation can be automatic, especially if there is interoperability with HIV/TB status, for age, gender, geographic area, if feasible.

ALIGNMENT

None.

REFERENCES

1. Health financing: Tracking universal health coverage (UHC) [online Q&A]. In: World Health Organization [website] (https://www.who.int/health_financing/topics/financial-protection/qa-tracking-uhc/en/, accessed 31 August 2020).

172. PROPORTION OF PEOPLE WHO REFUSED CARE AMONG THOSE TARGETED BY CHW

COMMENT

It is critical to measure the acceptability of services by people.

CHW TASK

Monitor when/which services are refused and why.

CHW DATA POINTS TO COLLECT

- Number of people who refuse care.
- Number of people targeted by CHW.

NUMERATOR

Number of people who refuse care.

DENOMINATOR

Number of people targeted by CHW.

DISAGGREGATION

Basic

- Type of service refused (vaccination, etc.)
- Age (0–4, 5–9, 10–14, 15–19, 20–24, 25–29, 30–34, 35–39, 40–44, 45–49, 50–54, 55–59, 60–64, 65–69, 70–74, 75–79, 80+)
- Gender (male, female)
- Geographic area

Advanced

- Reasons: Cost/no health insurance, fear of secondary effect, perceived lack of quality of services, perceived discrimination, confidentiality issue, third person consent, house duties, belief/religion, other

MATURITY LEVEL

B.

Longitudinal follow-up is key.

FREQUENCY

Monthly.

DIGITALIZATION

Disaggregation can be automatic, especially for age, gender, geographic area, if feasible.

ALIGNMENT

None.

REFERENCES

None.

173. EVENT/ALERT CASE DETECTED

COMMENT

In addition to CHWs, community leaders, volunteers and key informants can engage in CBS with training.

Which events or alert cases to track should be based on the local context and the diseases categorized by national policy as potential risks for public health. Examples include the customization of Integrated Disease Surveillance and Response (IDSR) diseases, and the diseases designated for CBS in each context.

It is critical to define the elements of response that need to be activated/acted upon and the systems of accountability after the report of events. The detection of a given event or alert should trigger immediate reporting through prior set communication channels, and appropriate feedback. Besides immediate reporting and response, it can be useful for CHW supervisors/CBS programmes to measure the aggregate number of events or susceptible cases with a certain frequency according to the nature of the event or cases (daily, weekly, or monthly), in order to monitor trends.

COVID-19

Where possible, individuals who have signs and symptoms of COVID-19 should be able to access evaluation and testing at the primary care level. When testing at the primary level is not easily accessible, individuals in the community, particularly CHWs, can play an important role in the surveillance of COVID-19. CBS may serve to bridge the gap between the community and the health system. (For more information, see: Community-based surveillance *(1)*.)

CHW TASK

- Detection and appropriate reporting of events or alerts (with traditional referral to health facility or isolation and visit from case investigation team to the household, depending on the suspected disease) from the list of those categorized by national policy as potential risks for public health.
- Referrals and alerts to local health officials for case investigation should also be paired with key health messages from the CHW directly related to the health risk identified (i.e. how to prepare ORS, how to reduce fever, practice physical distancing, etc.) in addition to traditional referrals.

NUMERATOR

Usually only the code for the suspected (specific) health risk, or whether or not an alert was triggered (event-based report – each case, group of cases, or event is reported individually; they are often tailored to single-counted based on the health risk).

CHW DATA POINTS TO COLLECT

Events or alert cases from the list of those categorized by national policy as potential risks for public health.

DENOMINATOR

None.

DISAGGREGATION

Basic

- Date/time (to later follow-up on the response time)
- Immediate reporting (yes/no)
- Type of event or alert case, from the list of those categorized by national policy as potential risks for public health (e.g. cluster of similar illness, suspected viral haemorrhagic fever, suspected COVID-19, suspected measles, etc.)
- Age
- Sex
- Geographic area
- Referral

Advanced

- None.

MATURITY LEVEL

C.

Data exchange with facility is critical.

FREQUENCY

Besides immediate reporting and response, it can be useful for CHW supervisors/CBS programmes to measure the aggregate number of events or susceptible cases with a certain frequency according to the nature of the event or alert (daily, weekly, or monthly), in order to monitor trends.

DIGITALIZATION

WHO has a corporate tool designed specifically for alert notification: EWARS *(2)*

The International Federation of Red Cross Red Crescent Societies (IFRC) and Norwegian Red Cross also have a platform that works to digitize simple SMS notifications into cloud-based data solution and integrated analysis using the Nyss platform *(3)* for CBS. This platform is designed to allow for both indicator-based surveillance as well as event-based surveillance. It includes human- as well as animal-related health risks, and has been built for multi-organizational use and collaboration (for example, to allow for ministry of health CHWs as well as Red Cross Red Crescent Volunteers and/or other local nongovernmental organization volunteers to all use the same platform while maintaining data privacy for each organization).

ALIGNMENT

None.

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174. PROPORTION OF CBS ALERTS RESPONDED TO WITHIN 24 HOURS OR WITHIN SPECIFIED TIME PERIOD FROM THE CBS PROTOCOL

COMMENT

It is critical to define the elements of response that need to be activated/acted upon and the systems of accountability after the report of events. The detection of a given event or alert should trigger immediate reporting through prior set communication channels, and appropriate feedback.

CHW TASK

Detection and appTrack timely response to CBS alerts

CHW DATA POINTS TO COLLECT

Time of response to CBS alert.

NUMERATOR

Number of CBS alerts responded to within 24 hours or within specified time period from the CBS protocol.

DENOMINATOR

Number of CBS alerts.

DISAGGREGATION

Basic

- Date/time of response
- Hours since CBS alert
- Type of event or alert case, from the list of those categorized by national policy as potential risks for public health (e.g. cluster of similar illness, suspected viral haemorrhagic fever, suspected COVID-19, suspected measles, etc.)
- Geographic area

Advanced

- None.

MATURITY LEVEL

C.

Data exchange with CBS response system is critical.

FREQUENCY

Besides immediate reporting and response, it can be useful for CHW supervisors/CBS programmes to measure the aggregate number of events or susceptible cases with a certain frequency according to the nature of the event or alert (daily, weekly, or monthly), in order to monitor trends.

DIGITALIZATION

WHO has a corporate tool designed specifically for alert notification: EWARS *(1)*

The International Federation of Red Cross Red Crescent Societies (IFRC) and Norwegian Red Cross also have a platform that works to digitize simple SMS notifications into cloud-based data solution and integrated analysis using the Nyss platform *(2)* for CBS. This platform is designed to allow for both indicator-based surveillance as well as event-based surveillance. It includes human- as well as animal-related health risks, and has been built for multi-organizational use and collaboration (for example, to allow for ministry of health CHWs as well as Red Cross Red Crescent Volunteers and/or other local nongovernmental organization volunteers to all use the same platform while maintaining data privacy for each organization).

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175. PROPORTION OF COMMUNITIES IN WHICH ACTION WAS TAKEN FOLLOWING AN ALERT (PER MONTH)

COMMENT

It is critical to define the elements of response that need to be activated/acted upon at community level and the systems of accountability after the report of events. The detection of a given event or alert should trigger immediate reporting through prior set communication channels, and appropriate feedback.

CHW TASK

Track initiation of response action following CBS alerts at the community level

CHW DATA POINTS TO COLLECT

Time and type of response action at the community level following a CBS alert.

NUMERATOR

Time and type of response action at the community level following a CBS alert.

DENOMINATOR

None.

DISAGGREGATION

Basic

- Date/time of action taken at community level
- Type of event or alert case, from the list of those categorized by national policy as potential risks for public health (e.g. cluster of similar illness, suspected viral haemorrhagic fever, suspected COVID-19, suspected measles, etc.)
- Type of community response
- Geographic area

Advanced

- None.

MATURITY LEVEL

C.

Data exchange with CBS response system is critical.

FREQUENCY

Besides immediate reporting and response, it can be useful for CHW supervisors/CBS programmes to measure the aggregate number of events or susceptible cases with a certain frequency according to the nature of the event or alert (daily, weekly, or monthly), in order to monitor trends.

DIGITALIZATION

WHO has a corporate tool designed specifically for alert notification: EWARS *(1)*

The IFRC and Norwegian Red Cross also have a platform that works to digitize simple SMS notifications into cloud-based data solution and integrated analysis using the Nyss platform *(2)* for CBS. This platform is designed to allow for both indicator-based surveillance as well as event-based surveillance. It includes human- as well as animal-related health risks, and has been built for multi-organizational use and collaboration (for example, to allow for ministry of health CHWs as well as Red Cross Red Crescent Volunteers and/or other local nongovernmental organization volunteers to all use the same platform while maintaining data privacy for each organization).

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